University of Alberta

The Transformational Journey of Acute Care Nurse Practitioners

By

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Words mean more than we mean to express when we use them; so a whole book ought to mean a great deal more than the writer meant. So, whatever good meanings are in the book, I'm very glad to accept as the meaning of the book.

~ Lewis Carroll, *A Selection from the Letters of Lewis Carroll to his Child-Friends* (1933/1973, p. 243 as cited *Alice's Adventures in Wonderland*, 1971, p. xxv)

When at the first I took my Pen in hand,
Thus for to write; I did not understand
That I at all should make a little Book
In such a mode; Nay, I had undertook
To make another, which when almost done,
Before I was aware, I this begun.

~John Bunyan, *Pilgrim's Progress* (1678/2003, p. 3)

Abstract

While the role of the acute care nurse practitioner (ACNP) has been studied, the research to date has focused predominantly on what functions they perform and how efficiently and effectively they perform them. A deeper understanding of who they are in their nursing practice has yet to be revealed. The purpose of this study was to explore the lived experience of being an ACNP with a view to deepening an understanding of and appreciation for their practice and the nature of the nursing care they provide. Using a hermeneutic phenomenological approach, 26 ACNPs from across Canada engaged in conversations that described their experiences in terms of what drew them to the role, their education and learning, seminal influences, the nature of their relationships, accounts of what they found satisfying and dissatisfying about their daily work, and clinical decision-making. The transcripts were subjected to a thematic analysis and reflective process which revealed that in their search for something more in who they can be as nurses and what more they can offer to others, ACNPs experience a transformational journey, all of which occurs in the context of being pioneers. The transformational journey includes: being called to be more – being more connected, being more in control, being more visible, being more challenged, and being able to make more of a difference; being adrift – being disconnected, being uncertain, being lost, and staying afloat; being an acute care nurse practitioner – being competent, being confident, being comfortable, being committed, being connected, and being content; being pulled to be more – being a wearer of two hats; and being more – being advanced practitioners. In keeping with hermeneutic phenomenology, other relevant sources of lived-experience material, such as literature, poetry, film, music, and art work, were woven into the evolving text. Therefore, this inquiry contributes to the growing body of substantive knowledge related to nursing practice as found in the everyday lived experiences of ACNPs.

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In nothing are our hearts as rich as in our memories, for they are pictures painted by our minds, and nothing can ever erase them. We have shared so much on our journeys together. Thanks to each of you for all the rich memories.

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CHAPTER ONE

ESTABLISHING THE GROUND FOR THE QUESTION

The role of the nurse practitioner[1] (NP) was first introduced in the United States in the 1960s. In the 1970s, the concept of an expanded practice role for nurses gained interest in Canada (Haines, 1993) and six Canadian universities offered programs to prepare NPs to provide primary health care, particularly to Canada's northern and rural communities (de Leon-Demaré, Chalmers, & Askin, 1999; Mitchell, Pinelli, Patterson, & Southwell, 1993). Approximately 250 NPs were educated in these programs between 1970-1983 and filled the perceived health care gap created by the physician shortages in the 1960s (Haines; van der Horst, 1992). Creation of the NP role, while controversial at times in terms of title and function, provided the nursing profession with an opportunity to expand its scope of practice and demonstrate nursing's impact on the health status of Canadians (Scherer, Fortin, Spitzer, & Kergin, 1977).

The competition for patients with increasing number of physicians in the late 1970s and early 1980s, combined with the absence of an effective payment structure from the Ministry of Health and little public understanding of the NP role, resulted in under utilization of the NP role and subsequent lack of practice opportunities (de Leon-Demaré et al., Mitchell et al.; Pringle & Graydon, 1993; Spitzer, 1984). Under utilization occurred despite the Boudreau Committee's recommendations that development of the NP role in primary health care be given a high priority (Boudreau, 1972). The NP educational initiative was withdrawn by the early 1980s as soon as sufficient physicians were again being trained. A lack of recognition of the nursing component within the NP role was a significant factor in the closing of the NP programs. A stigma of being a physician replacement resulted, perpetuated in part by increasing resistance to the role from both the medical and nursing communities (de Leon- Demaré et al.)

The need for cost containment and efficiency in health care, which demanded that innovative approaches to health care delivery be quickly developed and initiated, resulted in a renewed interest in the NP role in the early 1990s in Canada (Keane & Richmond, 1993; Mitchell et al., 1993; van der Horst, 1992). Additionally, advances in technology and higher levels of acuity and shortened hospital stays, combined with downsizing of acute care physician training programs in favor of generalist preparation (Barer & Stoddart, 1992a, 1992b, 1992c) resulted in increasingly fragmented care and shortages of in-house medical coverage for acutely ill patients.

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[1] The concept of nurse practitioner has had varied meanings depending on the context and the user's intent and understanding. In Canada, the title nurse practitioner (designated as NP) is not yet a protected one in every province. Although the title NP is often associated with those working in a primary care health setting, the use of the term NP throughout this study generically refers to a registered nurse (in any setting or practice) with in-depth knowledge of nursing gained through additional clinical practice experience and additional formalized education that builds on entry-level competencies gained through a baccalaureate education in nursing and who is authorized to integrate into his or her practice, elements such as diagnosing and treating health problems and prescribing drugs. Those working specifically in acute care settings will be referred to as acute care nurse practitioners.

These factors have been cited as the impetus for the widespread introduction of NPs into the tertiary care setting both in Canada and the United States (de Witt & Ploeg, 2005; Mitchell et al.; Pringle & Graydon, 1993). For example, in 1986, an unmanageable shortage of neonatologists prompted Ontario to train acute care nurse practitioners (ACNP) in neonatology. In the United States, the role of the NP in acute care settings has been implemented widely and studied since the early 1980s, although the oldest ACNP role is that of the neonatal ACNP which originated in the 1970s (Farah, Bieda, & Shiao, 1996). Since 1988, there has been an increase in the number of Canadian universities offering graduate-level nursing programs to prepare NPs for tertiary care (de Leon-Demaré et al., 1999; CIHI, 2005; CNPI, 2005b). It is anticipated that this number will continue to rise as provincial funding and legislative initiatives demonstrate political and economic support for this role.

As of March 2006, twelve jurisdictions in Canada have legislation and regulation in place or in progress, with eight of those jurisdictions recognizing ACNPs (Newfoundland and Labrador, Nova Scotia, Quebec, Manitoba, Saskatchewan, Alberta, the Northwest Territories and Nunavut) (CIHI, 2006; ANPEI, 2006). Nurse practitioner is a protected title in all but two jurisdictions with actual or pending legislation. The exceptions are Manitoba and Ontario, with the latter planning on submitting a proposal to government by the end of 2006 (Galloway, 2006). Despite these differences, the Canadian Nurses Association (CNA) in partnership with the provincial nursing associations and regulatory colleges in Canada have developed entry-level competencies for all NPs. They have recognized three streams of practice: family/all ages, adult, and child. The competencies for the NP streams of practice are based on the principles of primary health care (CNA, 2002a).

It is difficult to estimate the number of NPs in Canada, due to issues of titling, qualifications, and licensing, which are experienced both within and across provinces (CIHI, 2006; CNPI, 2004). The transition toward nationally accredited educational programs, a national NP exam, and protected NP titling will facilitate more accurate reporting of this information. However, the Canadian Institute for Health Information (CIHI) (2006) reported that, as of 2005, there were 1,026 licensed NPs registered in Canada, with the proviso that this number included only provinces and territories in which NPs were licensed separately from other registered nurses. This represented at least an 18% increase (range 18-340%) in the number of licensed NPs in each jurisdiction (where 2003 to 2005 data were available). The number of licensed NPs in Alberta increased by 73.7% (from 76-132), while New Brunswick saw an increase of 266.7% (from 6-22). Approximately 77% of licensed NPs were employed as NPs at the time of registration, with 26.9% of the NP work force employed in the hospital sector (CIHI).

This health care provider role, which has been surrounded with controversy since its inception in nursing, remains the focus of heated debates in both nursing and medicine with respect to its substitutability for or complementarity to the physician in health care (Billingsley & Harper, 1982; Gortner, 1982; Rogers, 1975; Sandelowski, 2000; Spitzer, 1984). This debate over complementarity or substitutability focuses on the comparison of NP practice with medical practice and fails to describe NP practice in its own terms. However, if NPs are to be accepted for more than their ability to respond to the shortages and surpluses of physicians and survive a second round of political exploitation, it is essential to place an emphasis on the NP as distinct from physician replacement. It is necessary to understand who they are in terms of the unique and significant contributions they make to the patient care experience. However, so much of what we see and read about NPs arises from objective research *about* what they do. As a result, the experiences of life-as-lived as NPs is concealed. The intent then is to disclose here in this study that which tends to be hidden by bringing into fuller view the ACNPs' lived experience from their own perspective, always keeping in mind that being an ACNP is experienced in the historical situation into which they were born, and within which they have lived and are now living (Aoki, 1983).

Orientating to the Phenomenon[2]

What is known about NPs? How have they been rendered knowable? What are the various discourses that have brought the phenomena of the NP into being? What is known about them that has not been part of the formal, dominant discourses? What has been silenced? A review of the literature was conducted chiefly to explicate what has been revealed about the nature of being an ACNP, to examine these questions in the context of our society, for we interpret and understand ourselves and others through the world's reflection as revealed in discourse (Gadamer, 1960/1989). "My discovering my identity doesn't mean that I work it out in isolation but that I negotiate it through dialogue, partly overt, partly internalized, with others" (Taylor, 1991, p. 47). The various cultural and historical patterns of thought and action have helped to produce the NP as such. These discursive formations are linked to power (Parker, 1997). Therefore, there are social and political consequences (Lawler, 1997) for the ways in which we know the NP.

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[2] A version of this section has been published. Rashotte, J. (2005). Knowing the nurse practitioner: dominant discourses shaping our horizons. *Nursing Philosophy, 6*, 51-62.

There are two types of discourses that have dominated the NP literature, both of which are alike and oft times indistinguishable: the instrumental and the economic. A third human sciences discourse related to the experience of being a NP and its meaning for nursing is almost invisible. Exploring these discourses helped to establish the ground for the research question.

Knowing the Nurse Practitioner: The Instrumental Discourse

Western society has come to know the NP through the dominant, highly valued instrumental anthropological discourse. Modern knowledge production has been based on a belief that its task is to build an adequate representation of people and things. This has been accomplished through the development of concepts and conceptual frameworks (theories) to represent experience and define who we are. From the time of their inception, NPs have been presented in the discourse as physical object and activity within an overarching framework of business (Daly, 1997a; Parker, 1997). As a point of illustration, it has been written that the NP is a true "hybridization" of nursing and medicine (Brykczynski, 1985). By combining the unique skills and abilities of the clinical nurse specialist (CNS) with medical knowledge and skills, the "retooled" nurse (i. e., the NP) has become an advanced practice nurse who is technically/clinically competent, flexible in collaborating effectively across disciplines and specialties, and highly marketable (Busen & Engleman, 1996; Sandelowski, 2000). What discourses in the literature have led us to know the NP in this way?

NPs have achieved visibility provided through the discourse on classification of roles, responsibilities, functions, and procedures. Adopting Benner's research exploring the development of clinical expertise, Brykczynski (1985) identified the domains and competencies of NP practice. Fenton and Brykczynski (1993) later completed a comparative analysis of the NP and CNS roles, which resulted in a modification of the NP practice model. Similarly, Hamric and Spross's (1989) framework for the advanced practice nurse (including the NP) centered on five domains of practice – expert clinician, consultant, educator, researcher, and leader/change agent. These and other similar models have formed the foundation for curriculum development (Calkin, 1984; Gilliss, 1996; Harper, 2000), the development of standards of practice (CNA, 2002b; CRNNS, 2002; NPAO, 1998), job description development (Bajnok, Grinspun, Hubley, & Shamian, 1994; CNPI, 2006; DeGrasse & Nicklin, 2001; Haddad, 1992b), performance evaluation (Buus-Frank, et al., 1996), and NP job analysis surveys (Alcock, 1994; Brady & Neal, 2000; Centre for Nursing Studies, 2001).

The prime focus of discourse within these domains has been associated with the direct clinical practice activities. Because of their link to instrumentation and technology, these activities are strongly associated with the highly valued medical model of cure. These activities are also the easiest to visualize, articulate, cost-analyze, and cost-compare. For example, the Nurse Practitioner Rating Form (NPRF) was developed to quantify both the nursing and medical components of the role (Goodwin, Prescott, Jacox & Collar, 1981; Prescott, Jacox, Collar, & Goodwin, 1981). The instrument allows for collection of frequency data and calculation of percent time spent in various assessment and management activities.

Similarly, there are numerous articles in the literature based on anecdotal accounts and research studies that list the types of procedures performed by NPs safely and efficiently (Brady & Neal, 2000; Clochesy, Daly, Idemoto, Steel, & Fitzpatrick, 1994; Kleinpell, 1998; Rust & Magdic, 2000; Shah, 1997). The list of technical skills can be extensive, depending on the specific context in which the NP works, but can include such procedures as suturing, lumbar puncture, arterial cannulation, chest tube insertion, endotracheal tube insertion, mechanical ventilation initiation and management, paracentesis, and wound debridement. In the discourse, the key factor differentiating NPs from other nurses and from other advanced, enhanced, and/or expanded nursing practice roles, such as the CNS, has been identified as the use of technical skills in ways previously denied nurses (OTA, 1986).

NPs are known as nurses who have been legally granted privileges to conduct advanced history and physical examinations; order and interpret diagnostic tests; diagnose medical conditions; communicate a diagnosis; plan and manage patient care in collaboration with a physician and/or team of health care providers, including ordering and performing therapeutic interventions that encompass both nonpharmacological and pharmacological therapies; and teach and counsel patients and family members (AACN, 2000; CNPI, 2004; Hubert, et al., 2000; NPAO, 1998). As noted by Sandelowski (2000), the instrumental discourse has led us to know NPs as "having gained deeper and cleaner entry into the bodies of patients, and more importantly into the domains of medical diagnosis and treatments" (p. 188). The degree of responsibilities in the advanced nursing practice areas of research, education, program and policy development, quality assurance, and professional activity involvement is known to vary widely and is often a small component of the job because of direct patient care responsibilities (Alcock, 1994; Fenton & Brykczynski, 1993; Kleinpell-Nowell, 2001; Roschkov, Urquhart, Rebeyka, & Scherr, 2004).

When the nurse moved into the medical domain as NP, it became necessary to know NPs in terms of their clinical judgment and decision-making abilities. The underlying assumption of the analytic approaches to understanding NP decision-making processes was that if NPs can be taught how to reach "correct" or "improved" decisions, they will make fewer poor decisions and patient care will improve. This discourse resulting from the research confirmed that NPs engage in decision-making processes similar to that of physicians (Carnevale, 2001; Offredy, 1998; Stroud, Smith, Edlund, & Erkel, 1999). As a result the quality of care provided by NPs has equaled and, in some instances, exceeded that provided by physicians in the same practice, as well as enhanced collaborative relationships with all members of the health care team (Feldman, Ventura, & Crosby, 1987; Lewis, Resnick, Schmidt, & Waxman, 1969; Mitchell et al., 1991; Mitchell-Di Censo et al., 1996; Mundinger et al., 2000; Rudy et al., 1998; Sidani et al., 2004; Spisso, O'Callaghan, McKennan, & Holcroft, 1990; Spitzer et al., 1974).

Results from many studies over the last four decades have consistently produced evidence of the quality of care provided by NPs using physician care as the standard of quality and physicians as the comparison group. In addition, studies have confirmed that patients are accepting of and satisfied with NP services (Brands, 1983; Holbrook & Shamansky, 1985; Kinnersley et al., 2000; Rhee & Dermyer, 1995; Shum et al., 2000; Spitzer et al., 1974; Trotter & Danaher, 1994). In summary, the authors of comprehensive report after comprehensive report have concluded that NPs are successful and effective, no matter what measure is used or what question is addressed – access, availability, acceptance, satisfaction, cost or clinical outcomes (Abdellah, 1982; Brown & Grimes, 1995; Crosby, Ventura & Feldman, 1987; Edmunds, 1978; Feldman et al., 1987; Freund, 1993; Horrocks, Anderson, & Salisbury, 2002; Molde & Diers, 1985; Piano & Zerwic-Johnson, 1998; Prescott & Driscoll, 1979, 1980; Rudy et al.; Standford, 1987). Furthermore, this evidence is growing from around the world, confirming that NPs provide quality health services in a range of settings (ICN, 2001). Thus, NPs are known through the discourse as being providers of safe, competent quality patient care equivalent to that of physicians.

NPs are also known in terms of their demographic data, educational preparation, geographic region of practice, years of employment, and type of employment setting (Alcock, 1994; Brady & Neal, 2000; CIHI, 2006; Kleinpell-Nowell, 1999, 2001; Sidani et al., 2000). For example, both the American and Canadian data inform us that NPs are predominantly white, middle aged, and female. Although in Canada there are inconsistencies among provinces/territories in the educational preparation of registered nurses for the NP role, including masters, baccalaureate, diploma, and certificate programs, the discourse tells us to expect the NP to be educated at the graduate nursing level with a primary or acute care NP program of study (Alvarado, Keatings, & Dorsay, 2003; CACCN, 2003; CNA, 2002b; CNPI, 2005b; CPS, 2000; Haddad, 1992a, 1992b).

The NPs have been differentiated by a number of specialties, such as, primary care, acute care, neonatal, pediatric, adult, geriatric, occupational health, women's health, school health, family practice, and mental health. They have been categorized by practice settings such as northern outposts, rural clinics and physician offices, patient's homes (CIHI, 2006; Naylor et al., 1999), school settings (DeMaio, 1981), nursing homes (Kane et al., 1989), industry, and hospitals (in ambulatory care, emergency departments, and in-patients units) (CIHI; Glenn et al, 1997; Hanna, 2000; Rust & Magdic, 2000).

The strength of this discourse is that NPs are known as a group of health care providers who have the ability and willingness to improve accessibility to care for geographically underserved populations (Richardson, 2001) and for medically vulnerable groups not adequately served by physicians. Consequently, they are also known as being competent to "shepherd" (Daly & Genet, 1997) individuals through today's complex health-care system as they care for children and adults with long-term health care problems (Daly, Rudy, Thompson, & Happ, 1990) or acute illnesses (Silver, Murphy, & Gitterman, 1984; Spisso et al., 1990), including those in need of intensive care (Mitchell et al., 1991). This differentiation and broadening of the scope of practice of NPs has helped us to know NPs as advanced practice nurses with versatility, flexibility, adaptability, and sustainability. They are not merely physician substitutes "that serve their purpose only temporarily before their usefulness expires and they are displaced by physicians" (Brooks, Bernstein, DeFriese, & Graham, 1981, p. 254).

Through the discourse the NPs' role is known in various but disparate ways as a result of how it has been operationalized within the business of health care. There has been a lack of uniformity of position titles, academic requirements, reporting relationships, and differences in the functions and activities (Alcock, 1994; Centre for Nursing Studies, 2001; CNPI, 2004; CNSIGO, 2002; DeGrasse & Nicklin, 2001; Dunn & Nicklin, 1995; Hunsberger et al., 1992). Administrative leaders have further added to role confusion through the creation of incongruence between implementation and the role descriptions. Research studies have found that someone whose qualifications were less than those mandated frequently fulfilled functions of a NP role (Alcock). Sometimes NPs who met the requirements assigned to the role were not able to adequately carry out role functions because the demands of the job were prohibitive (Kleinpell-Nowell, 2001). As a result, the importance of administrative support to implement the NP role effectively and to secure job satisfaction has been widely researched. The discourse on barriers to effective NP utilization have included discussions of resistance from staff nurses; inability to refer clients to other disciplines; inability to prescribe; incongruence in role expectations between the administrative leader, medical staff, and NP; lack of organizational understanding of the role; lack of authority to make change; lack of a protected title; lack of mentorship; lack of hard data to demonstrate the worth of their caring nursing functions; lack of salary recognition; ineffective collaboration with physicians; and restriction from using the full scope of their medical knowledge and skills (Centre for Nursing Studies; CNPI, 2005a; Dunn & Nicklin; El Jardali, 2003; Evans, Jones, Way, & Paes, 1997; Irvine et al., 2000; Patterson, Pinelli, & Markham, 1997; Reay, Golden-Biddle, & GermAnn, 2003; Van Soeren & Micevski, 2001).

Knowing the Nurse Practitioner: The Economic Discourse

> Nurse practitioners are a proven response to the evolving trend towards wellness and preventative health care.... NPs cost 40% less than physicians and are particularly cost-effective in preventive care....NPs manage 80-90% of what primary physicians can do without the need for consultation or referral. ...The cost of an office visit to see a NP ranges from about 10%-40% less of the cost for comparable primary care services by a physician. NPs deliver health care at 23% below the average cost of other primary care providers with a 21% reduction in hospital inpatient rates and 24% lower lab utilization rate below physicians. ...NP use plays a part in [Health Management Organization's] strategies to control costs. ...[A]dding a NP to the practice could virtually double the [number] of clients

> seen by a physician…a projected increase in revenue of …approximately $1.65 million dollars per 100,000 enrollees per year. (AANP, 2002)

The second dominant discourse in the literature related to the NP centers on economics. It has been explicated that the changes in the health care system spurred the revitalization of the NP movement in the 1990s (Dunn & Nicklin, 1995; Glenn et al., 1997; Haddad, 1992a, 1992b; Noesgaard & Hoxby, 2000); that is, the real impetus for the invention of the NP role came from the economic sector. The NPs have been viewed as health care providers who are qualified to efficiently and effectively meet the new demands created by the changes in the health care system (Sidani & Irvine, 1999) through the incorporation of medical and advanced nursing functions and responsibilities. NPs became viewed as a tool for more cost-efficient primary and acute health care, as well as to make up for the decline in numbers of resident physicians in hospitals (deliberately engineered in response to an anticipated oversupply of specialist physicians) (Barer & Stoddart, 1992a, 1992b, 1992c). The NPs of the 1990s are what health care administrators, policy makers, and financiers ordered to fix a system perceived as "dysfunctional and inadequate" (Daly, 1997a, p. 3) and to control the escalating costs of health care while attempting to maintain quality (Sandeloswki, 2000).

An illustration of the economic-driven discourse that besets the NPs has been the way the growth of the health care costs has been used to justify replacing physicians with cheaper labor (i.e., NPs). NPs have repeatedly been promoted as a cheap, albeit excellent, alternative to physicians. For example, the most oft cited work in the NP literature is the U. S. Congress policy analysis completed by the (ironically entitled) Office of Technology Assessment (OTA) (1986). Through an extensive review of the literature on efficacy, safety, and costs of specific "technologies" (i.e., NP implementation), this organization predicted the potential contribution that NPs might make to health care costs and quality. The OTA report demonstrated that productivity studies indicated that NPs working under physicians' supervision could increase total practice output by some 20-50 percent (p. 6). It also stated that indirect evidence indicated that NPs could decrease costs to employers and society, while increasing productivity of medical practices and institutions (p. 10).

Similarly, Denton, Gafni, Spencer, and Stoddart (1982) combined cost and demographic projection models to estimate potential savings related to the role of the NP for the Canadian health care system. They concluded that approximately 10% of all medical costs and 15.9% of all ambulatory costs could have been saved in 1980 if the services of a NP had been substituted for a physician where appropriate. Lomas and Stoddart (1985) estimated that in 1980, 20-32% of general practitioners in Ontario could have been replaced by NPs to produce these projected savings.

Multiple studies in a variety of settings and patient populations have continued to verify these conclusions confirming that NPs improve the public's access to high quality care at cost savings to the system (Aiken et al., 1993; Bissinger, Allred, Arford, & Bellig, 1997; Brooten et al., 1986; Brown & Grimes, 1995; Feldman, et al., 1987; Hall et al., 1990; Kinnersley et al., 2000; McGrath, 1990; Mundinger et al., 2000; Naylor et al., 1994; Safriet, 1992; Shum et al., 2000; Spitzer, Roberts, & Delmore, 1976; Stetler, Effken, Frigon, Tiernam, & Zwingman-Bagley, 1998; Venning, Durie, Roland, Roberts, & Leese, 2000). It has been strongly suggested that these types of findings "should be on the tip of the tongue of anyone trying to 'sell' the concept of nurse practitioner as preferred health care provider" (Buppert, 1995). Indeed, nursing and NPs must promote this discourse (CNA, 2002c; Davis-Doughty & Keller, 2000; D. Taylor, 2000).

The economic-driven discourse has also been focused on how the NPs measure up in terms of quality-care and cost-efficiency as compared to that of the physicians. For example, their care has been measured in terms of volume of patients seen per day; average length of hospital stay; rate of readmission; mortality and morbidity; number of drugs prescribed, diagnostic tests ordered, consultations and referrals made, correct diagnoses; days on oxygen and/or ventilator; and monthly cost of care per patient (Bissinger et al., 1997; Buppert, 1995; Ingersoll, 1995; Kinnersley et al., 2000). Ironically, this same discourse, which depicts the NPs as risk takers who are successfully pushing the professional envelope (Brown & Draye, 2003), has triggered a discourse of skepticism, animosity, and rejection with a view of the NP as a territorial invader both within and between professions and second rate health care providers "to whom patients are being brushed off" (Blakeney, 2002; Centre for Nursing Studies, 2001). Numerous articles describe the resistance to the NP role (Betz, 1994; Bigbee & Amidi-Nouri, 2000; Christman, 1998; Draye & Brown, 2000; Evans et al., 1997; Rogers, 1972; Way, 2001).

Brooten and Naylor (1995) argued that, while there is a need to continue to include these forms of measurement because the information they provide are well understood by others, they are limited because they fail to capture the NPs' actions that effect these outcomes. Therefore, they called for research that identifies and examines nursing interventions (or "nurse-sensitive patient outcomes"). The expressed intent of this focus for research would be to determine the dose (i.e., the amount and type of nursing interventions used by the NP) necessary to yield changes in patient outcomes, which could then be prescribed under specific contexts (p. 98-99).

In a like manner, numerous nursing authors have provided advice on how to better explicate the ways in which the NPs achieve cost reductions in their practice, thereby proving their "value-addedness" (Byers & Brunell, 1998; Carroll & Fay, 1997; Clochesy, 2002; De Bourgh, 2001). The driving force behind this initiative is the understanding that the national trends to replace costly health care providers with less prepared personnel also places their own positions in jeopardy. If the NPs' continued survival is based only on current medical and economic values then their existence will continue to be tenuous. For example, NP performance evaluations are now centered on the documented ways in which their care has been of high-quality with increased efficiency and cost savings to the system (Gedwill, Mack, Mlakar, & Vanek, 1997; Hylka & Beschle, 1995; Kearnes, 1992). There is also a trend toward the concept of "economic credentialing," a system in which the NP may have a contract or selected clinical privileges denied or withdrawn when he/she is deemed economically inefficient (Hravnak & Baldisseri, 1997). Yet, it is argued that it is the visualization of productivity related to services rendered that leaves the NP with a sense of gratification (Gedwill et al., p. 163).

The medical "cure" model and economics, not nursing ideals, remain "the gold standard" against which the NP is promoted and judged. It has been repeatedly demonstrated that NPs are more adept than physicians at providing services that depend on communication with patients and preventive actions (OTA, 1986). Patients are generally satisfied with the quality of care provided by NPs (OTA), particularly with the interpersonal aspects of care (Avorn, Everitt, & Baker, 1991; Johnson, 1993; Lewis & Brykczynski, 1994; Prescott & Driscoll, 1979). NPs have demonstrated that they spend time with patients to help them define goals, choose alternatives, and identify interventions that will address health problems, in addition to physiologic dysfunction. These nursing "care" activities are valued by the patient and potentially lead to more economical approaches to care (Avorn, et al., Fisher, 1995). However, these non-quantifiable aspects of the NP role receive no remuneration, are not measured, and thus lie outside the current discourse. Therefore, this way of knowing the NP is not available. In fact, the notion of primary care, health promotion, and psychosocial support are inherently seen as less complicated services than those deemed "medically complex." Indeed, NP work has been represented as that which physicians find "mundane, routine and thus eminently delegable to nurses," thus saving physicians for more complex (i.e., technically and intellectually) activities (Centre for Nursing Studies, 2001; Silver & McAtee, 1988).

Clearly, the desire to capture the essence of what the NP does is an example of "our ability to get everything clear and under control" (Dreyfus, 1993, p. 301). The strength of this way of knowing the NP has been its delineation of the role with its various components and competencies. Characteristic of the instrumental discourse, the presentation of the NP has been objective, precise, descriptive, and informative. The discourse has invited distance and detachment rather than engagement with the subjective (Lawler, 1997, p. 35) resulting in the NP being anonymous, depersonalized, and passive. The strength of this discourse has been its delineation of the NP's role with its various components and competencies. This approach is logical and appropriate, given that understanding any new role can be facilitated by breaking it down into manageable parts (Davies & Hughes, 1995). As argued by McTavish (1979), once the role of the NP is clearly defined, the functions specifically stated, the activities objectively evaluated, the educational preparation analyzed, then and only then can some of the practical barriers and resistance to the utilization of the NP be removed (p. 43). Articulated in another way, "How can someone be licensed for something if it isn't clear what that 'something' is" (McTavish p. 43)? It is only then that it can be articulated to others what it is that the NP role can provide to the system and ultimately to the patient, and hopefully result in appropriate remuneration and autonomy of practice legislature. Ironically, it is not until NPs are known in terms of a functional analysis that they can be brought under the health care system's control and turned into an economic-driven resource.

Again, the strength of this discourse has been its ability to provide nursing with the ammunition necessary to successfully lobby for NP role implementation. First, this form of discourse provides the public and the professions with the assurance that NPs are not providing second class or low-quality care (Ford, 1982). Second, cost-effectiveness data help to energize and mobilize into action those groups who carry the power to influence the health care system at the provincial and local levels. As D. Taylor (2000) so aptly noted, lobbying effectiveness has a strong influence on government policy-making (p. 87). Legislators listen when nursing can speak to promote better utilization of services at a reduced cost with the same or better quality of care. By utilizing this form of discourse, the NPs have been able to market themselves as a viable commodity in the business of health care. Third, this information better enables administrative leaders to successfully implement sustainable and satisfying NP roles in the health care organizations. This has been verified in research (Reay et al., 2003) and is currently depicted in *The Implementation and Evaluation Toolkit for Nurse Practitioners in Canada*. This toolkit offers practice advice and tools to users for assessing the need and readiness for NP implementation, as well as the key steps and factors that will support successful NP implementation and ongoing monitoring (CNPI, 2006). By better understanding the NP in this way, administrative leaders can support and encourage the NPs' development and empower them to perform to their full potential, both in terms of their scope of practice as well as in their leadership abilities.

Yet ironically, the same approach that is used to justify the legitimacy of the NP role has served to maintain the same system under which health-care is delivered, a system that often fails to meet the needs of the patients, especially in a manner desired by both patients and NPs (Sandelowski, 2000). Hospital administrators and governments consider NPs to be an expensive solution when they are "deployed" simply as "add-ons" to everything else they do rather than as "substitutes" (D. Taylor, 2000, p. 94). When NPs engage in discourse related to how they can enhance or complement health care services and work in partnerships with their medical colleagues, a different health care delivery model must be envisioned if one is to anticipate cost-savings (Daly, 1997a). Otherwise, those controlling the budget see the patients receiving "extras" within a system already financially out of control. Yet, the restrictions placed on the NPs by provincial regulations discourage the integration of these providers into the system in any other way except in the traditional hierarchical and subservient way. For example, the NP is often referred to as a "mid-level care provider." This language insinuates that the NP is placed at a level below that of the physician within the medical ranks while at a level above that of the general bedside nurse in the nursing ranks. Sadly, this form of discourse has also served to strengthen the already forged class system in nursing (Northrup et al., 2004). Society expects physicians to be at the top of the health care hierarchy and assumes that physicians know more about all matters of health and disease than any other provider. Thus, society is highly responsive to "professional discourse" that reinforces these expectations (Buppert, 1995).

However, it is within the modern view of technology where NPs are viewed as a commodity that we can understand why NPs are defined in the discourse in terms of their functions – in their "in-order to" role. In this discourse the NP has been viewed as a physical thing like any other mechanical machine whose functions have been identified, classified, and analyzed. In the language of technology, the NP discourse is more like a type of audit, such as checking up on what has been attained (the outcomes) or looking over the operations and implementation, evaluating its on-going function or its breakdown. Even the discourse related to the managerial care of the NP can be viewed more as the way in which supervisors care for their tools in order to generate high productivity and enhance retention (Dreyfus, 1993, p. 177). The understanding of what the NP role entails, achieved through the visibility provided by the classification of functions and procedures, as well as the cost-effectiveness of the NP role, makes the NPs a target for management by others. The attraction (and potential danger) of itemizing NP activities is that they can serve to regulate the NPs' work and establish their worth to the system. For example, Kleinpell-Nowell (1999, 2001) reported that ACNPs work on average 50 hours/week in direct patient care activities (range 40-80 hours/week) with 45% working off-shifts and weekends for a set salary that is at least 50% less than that of the physicians. Additional advanced nursing practice functions of their role, such as research, teaching, program development, and administrative responsibilities are completed on their own time.

Charles Taylor (1991) wrote that because Western societies value the primacy of instrumental rationality, we necessarily draw on this form of reasoning to "calculate the most economical application of means to a given end. Maximum efficiency, the best cost-output ratios, is its measure of success" (p. 5). It is then that the information can be set up as a problem-solving activity for science to turn into predictive and probabilistic data. As he argued, although this societal redesign has been liberating, the dark side has been a flattening and narrowing of our lives, making them poorer in meaning and less concerned with others. "The fear is that things that ought to be determined by other criteria are decided in terms of efficiency or "cost-benefit" analysis, that the independent ends that ought to be guiding our lives will be eclipsed by the demand to maximize output" (p. 5). As has been demonstrated, the NP literature is replete with research that gives substance to this concern. As noted by Lawler (1997) on nursing, "economic discourses and methodologies have distracted and misled us, and worse – have seduced us into formalizing our knowing of…nursing care in a form which is more meaningful and useful to economists and managers than it is to practicing nurses" (p. 40). Lawler's observation also strongly applies to the discourses related to NPs (Rashotte, 2005).

The construction of the NPs' role in terms of the delineation of its various parts and cost-effectiveness is not capturing who the NPs are and the nature of their work; rather it reinforces the idea that NPs are only what they visibly and measurably do. As argued by Sandelowski (2000), the instrumental language used in describing the NP is the "most pervasive," and because it is considered the "most powerful" language in our society, NPs have "borrowed" the language of science and economics to respond pragmatically to a prevailing economic climate. In the prevailing discourse around the NP, the role emerges as a largely economical and "medically-driven model of practice" (Betz, 1994, p. 140). Although the instrumental and economic discourses have allowed NPs to get into the contemporary health care "game," these discourses have also silenced the NPs' voices (Lawler, 1997, p. 45). As a consequence, the traditional image of nurses (in the NP role) as the extra hands and eyes of physicians willingly and cheaply filling voids and bridging gaps in health care is maintained (Sandelowski, p. 190). As Daly (1997a) noted, the "best recognized function" of the NP is to "substitute for physicians, to deliver cost-effective...care" (p. 5). The primary point of reference for the NP is arguably not truly nursing but, instead, medicine and economics (Sandelowski, p. 190).

Summarily, in this age of modernity, the NP has come to be constituted as a machine or tool to be scrutinized for its uses and efficiencies within the work place. The research to date may have allowed us to know the NP in terms of what the role is, but not in a way that provides a space to know who the NP is, their interior life, and of what it means to be an NP. In becoming an object, the NP as a tool has been separated from the essential person as nurse. The discourse arising from the research to date has not captured the myriad of dimensions of the NP role and their practice. We have failed to capture how NPs view their world. The full measure of what NPs have to offer their patients has yet to be brought to light. There is little mention of the NPs "hidden riches" (Dreyfus, 1992, p. 177). The dominant discourse, for instance, has not made visible the time and skill it takes to be physically, personally, and existentially available to the patient, although a few significant qualitative studies have begun to surface that counterbalance the traditional ways of knowing the NP.

Knowing the Nurse Practitioner: The Human Sciences Discourse

> Here's an example of how important listening is. This guy had been in and out of emergency rooms and spent thousands of dollars on tests and EKGs and various other things...He ended up here out of frustration and exhaustion. I saw him in the ambulatory clinic after the ER triaged him over. He presented with his mother. I remember walking into the room and seeing that they were frustrated, scared, and upset about the fact that he was having all this severe pain. With all the money spent and all the tests having been done, nobody knew what was wrong with him, and no one was able to fix it at this point. I did the same thing with him as far as listening as I do for all my patients. I put the chart down and didn't look at it. I had him start at the very beginning. He had six or eight months of these periodic bouts of severe squeezing chest pain. His mother was sitting over there almost in tears thinking he's going to die.
>
> After listening, I tried to summarize what he had told me to validate the story. Finally, I looked at him and said, "What are you concerned about?" His mother answered, "We're concerned about his heart. We think he's having a heart attack." My first statement was, "If it was a heart attack, he'd be dead by now, and they could have found that out on all these EKGs they were doing. Obviously, it's not that because they've been stone cold normal." Just then you could see the relief in her face – like nobody had ever said that or brought it down to that level. They were like, "Whew! I feel better already."
>
> We then started working through the possibilities, and I introduced the idea of esophageal spasms being in his chest with squeezing tight pain. He looked at me and said, "That sounds exactly like what's going on!" Taking the time to listen to his story made the whole thing come together. I remember the tension that they came in th[illegible]m with and the relief they went out with, and they felt better immediately. (Brykczynski & Lewis, 1997, pp. 525-526)

A third discourse is just beginning to emerge in the literature related to the NP movement. However, the paucity of research that views the NP role from an ontological perspective pales in comparison to the sheer volume of research associated with the instrumental and economic discourses. Why has it taken nearly thirty years for this way of knowing the NP to come into view? Perhaps, the answer lies in the evolutionary process of knowing as embedded in Western philosophical traditions. As Edmunds (1978) has argued, the NP is known through the discourses of the NPs' evolution. In the precursive stage, efforts were directed at winning support for the continuing development of the role through discourses that communicated the experiences of the programs and their graduates. The second stage was one of role definition and legitimization, in which the competence of the NP to assess and manage health problems was ascertained. The current stage is that of emphasizing and validating the quality of care provided by NPs, their influences upon employment settings, costs, distribution, and education. It appears that now there may be a readiness and openness on the part of some researchers to explore and make visible other important ways of knowing the NP.

Brykczynski (1999) has argued that the core of nursing (and thus NP practice) cannot be defined by the tasks NPs perform. This led her to ask the same question posed by Weston (1975): "Whither the nurse in nurse practitioner?" In their explorations of NP nursing practice from an ontological perspective, Lewis and Brykczynski (1994) found that NPs engage in responsible risk taking and the skilled healing practice of personal persuasion. They found, for example, that responsible risk taking helped promote increased understanding of the mutuality of decision-making (Brykczynski & Lewis, 1997), illustrating Gadow's (1980) concept of existential advocacy. "[NPs] open up a window of understanding on the processes of 'being with,' of presencing oneself in the lived experience of the patient's world and trying out ways to participate with patients in making decisions and learning to live with their particular health and illness situations" (Brykczynski, p.180). Similarly, the narrative excerpt provided at the opening of this section, illustrates the healing role of the NP, as revealed in the art of listening and attending. Brykczynski argued that the ability of NPs to offer something unique, which impacts on patient outcomes, is related to differences in the process of care and the patient-provider relationship. These are relationships of caring that are personal, egalitarian, collaborative, and involving mutuality. These findings have been similarly found in Beal and Quinn's (2002) phenomenological study of NP care-delivery in a newborn intensive care unit as perceived by parents. Brown and Draye's (2003) exploration of the NP pioneers' experience of establishing the role confirmed that the hallmarks of NP practice and job satisfaction were the relational aspect of the role, mutuality, shared decision-making, and personal connections, enabled through an autonomy of expert extended practice.

In a study using discourse and ethnographic analysis, Johnson (1993) focused on NP-patient conversations in order to understand the positive outcomes of NP care. She explained that in the education and subsequent practice of NPs, medical management is incorporated into the nursing perspective. The importance of the medical component is acknowledged, yet the holistic person-oriented focus of nursing remains paramount. She argued that there is a postmodern blending of nursing and medical knowledge and skills in the NP role – an "and" rather than an "either-or." She suggested that NPs might be described as androgynous, since they incorporate aspects of both nursing (a traditionally female occupational role) and medicine (a traditionally male occupational role). Building on Johnson's work, Brykczynski (1996) described NPs as "tricultural and trilingual." She stated, "they share background knowledge, practice, and skills of three cultures: (1) biomedicine, (2) mainstream nursing, and (3) everyday life. In other words, they are fluent in the languages of biomedical science, nursing knowledge and skill, and everyday parlance" (p. 85).

In summary, this handful of studies from a human sciences perspective has started to illuminate the ways in which NPs are with patients and families. The strength of this type of emerging discourse is that it has the power to reveal some of the qualitative distinctions and commonalities in the practice of NPs and physicians. In contrast with the instrumental and economic discourses, the human sciences discourse has the strength to elucidate the NPs' unique contribution to health care. This way of knowing the NP has the power to help us understand in a deeper and richer way the more elusive process of nursing care as it is revealed in the NP role. Enhanced understanding of the ontological nature of NPs' work brings into open discourse aspects of nursing care that have been largely covered over and not acknowledged explicitly.

The Research Question Arises

> I felt like a voyeur as I watched her work with both the baby and the mother, all the while pretending to read another patient's chart. I understood from her explanation to the mother that the baby was showing signs of a systemic infection and therefore needed to start antibiotics right away. She was preparing to insert an intravenous catheter into one of the baby's central veins, which would be the best way to administer the medication over the next week or so. Her name was Beth and I knew her to be a neonatal nurse practitioner with five years of experience in this role. Her movements were methodically sparse as she gathered the equipment from the shelves, and her soft, gentle voice seemed to soothingly take me through the steps of the procedure she was about to undergo with this sick infant. She offered the mother the choice to wait outside the unit or to remain at the bedside, then helped her to situate the stool across from where she would be working, facilitating the mother's access to the proceedings. She gently positioned the baby, intermittently stroking the baby's head and massaging his feet, and then with the assistance of the baby's bedside nurse, she silently undertook the procedure. I was in awe of her composure and self-assurance embedded within her demonstrations of caring, and at some unidentified point during this time, I knew that I trusted the baby's care in her hands. Not long after, the procedure completed, I noted that she cleared away the debris while the bedside nurse and mother resettled the baby. When the mother returned to the rocking chair by the bedside, Beth sat down beside her and I heard her ask the mother what was the most pressing concern she had at that moment. I could see the mother was crying as she expressed her regret that the strides she had finally been able to make with her baby taking the breast would be halted, just another reason to feel like a failure as a mother. Beth gently took the mother's hands into hers. Suddenly it felt obtrusive being there, so I quietly left the area, proud in knowing that this mother too was in the safe care of the acute care nurse practitioner. ~ J. Rashotte

Researchers are drawn to study that which has personal significance. I am not a NP. However, I have heard physicians say to student NPs, "You need to think more like a physician." I have heard student and novice NPs express their regret about the decision to become a NP because they no longer felt like nurses and did not want to be physician replacements. Through their tears, I have heard them repeatedly ask, "Where is the nurse in what I do?" I have been involved in administrative decisions that determined if NPs or physicians would provide the medical care in those areas that were experiencing resident shortages, decisions that focused entirely on discourses regarding cost-effectiveness and over-lapping functionalities. Yet, this story about what I observed as Beth cared for a sick infant and his mother is not an isolated one. I have been witness to ACNPs who massage their patients' limbs before and after performing an invasive procedure, or who hold in their arms the fathers and mothers they have just informed their child was going to die. Is what I have seen just particular to these ACNPs or has the way in which they embody their practice just not been given a voice?

At the heart of the way in which NPs are known are recurring themes and core narratives of efficiency, economy, shifting trends, and changing roles. The ways of knowing the NP in the dominant discourses of instrumentalism and economics are valuable. They have offered ways for nursing to articulate to others what it is the NP does and have been useful in making this role visible and legitimate in a way that is acceptable within our society. However, it is imperative that the risks inherent in these discourses be understood if they remain the only way or dominant way of knowing, both for the NP and for nursing. The NP predominantly is known as "objectless." They are known and understood in the way in which our society has understood the term "essence", that is, in terms of *what* something is. However, in explicating what has been revealed about the nature of the NP, a deep understanding of *who* they are has yet to be achieved. Indeed, the near exclusion of reference to the ontological nature of the NPs through a human sciences discourse is disconcerting. Only recently have some nurse researchers gone beyond these models and focused on identifying and describing what is unique to nursing. "The language of positivistic social science and the natural sciences [has been] too impoverished to give an adequate account of what actually occurs in everyday life" (Benner & Wrubel, 1989, p. 41).

No suggestion is being made here that in order to strengthen the human sciences discourse we need to move away from the instrumental or economic discourses. In fact, that would be as harmful as the present situation. An either/or stance is not desirable. As noted in the work of Ludwig Wittgenstein(1968):

> As in spinning a thread, we twist fibre on fibre. And the strength of the thread does not reside in the fact that some one fibre runs through its whole length, but in the overlapping of many fibres. (p. 32)

However, it is readily apparent that our way of knowing the NP is incomplete. Bowker, Timmermans, and Star (1995) wrote: "A light shining in the dark illuminates certain areas of nursing work, but may cast shadows elsewhere" (p. 363). The whole picture is a complex one and it is time to make the invisible, visible. It is time to advance the exploration of the NP ontologically in a new way, so that the conversation can be opened up between different realms of discourse. In the words of David Jardine (1998), it is a matter of "getting in on the conversation," for it is in this way that the conversation can be kept alive, even though it may be full of conflict and ambiguity.

Gadamer (1960/1989) showed in a most unforgettable way in *Truth and Method*, that when a question "presses itself upon us, we can no longer avoid it and persist in our accustomed opinion" (p. 366). Therefore, the pressing question for me that guided this study was – *What is the nature of the lived experience of being an ACNP?* The purpose of the study was to explicate the meaning of the lived experience of being an ACNP and subsequently, to seek a deeper understanding of the nature of their nursing practice.

CHAPTER TWO

RESEARCHING THE ACUTE CARE NURSE PRACTITIONERS' EXPERIENCE

The question of being an ACNP[3] is one of meaning – *what is the nature of the lived experience of being an ACNP?* or *what does it mean to be an ACNP?* Such a question calls for attention to the ACNPs' voices about their own experiences in the situation of our current society and health care system. Decontextualizing the ACNPs' experiences loses the meaning that needs to be captured. There can be no separation of the knowledge of the experience from the meaning of the experience for "meaning resides not solely in the individual nor solely in the situation but is a transaction between the two so that the individual both constitutes and is constituted by the situations" (Benner, 1985, p. 7). Therefore, in congruence with the question and with the intent to enrich understanding of the experience of being an ACNP, a hermeneutic phenomenological approach provided the foundation for this study. It is hermeneutic phenomenological inquiry that elicits human experience, including thoughts, feelings, perceptions, and descriptions of the events and interactions in which human activity is situated (Benner, 1994; Leonard, 1994; Thompson, 1990; van Manen, 1997). Grounded in the foundational writings of philosophers such as Husserl (1970), Heidegger (1927/1962), Merleau-Ponty (1945/1962) and Gadamer (1960/1989), hermeneutic phenomenology, which seeks to disclose meaning as encountered in the lived world, offers a way to understand the nature of being ACNPs as found in their everyday lived experience, rather than providing a narrow and objectifying "explanation" resulting from traditional empirical-analytic studies.

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[3] To facilitate congruence between this study and other significant research on the ACNP role, this study's definition of an ACNP was adapted from the Canadian published literature. The ACNP was defined as a registered nurse with additional educational preparation from an accredited university-based NP program with supervised clinical practice in an acute care specialty practice. The ACNP practices in a variety of settings and specialized services within secondary, tertiary, or quaternary level facilities, integrating the skills and knowledge from nursing and medicine within a broad framework of advanced practice nursing. The ACNP functions both autonomously and in collaboration with physicians and other health care providers to manage, in a comprehensive manner, the complex, health care needs of an assigned number of acutely or critically ill patients. The ACNP has advanced knowledge and decision-making skills in assessment such as history taking and physical examination, diagnosis, and health care management. The ACNP is prepared to demonstrate knowledge in advanced pathophysiology, identify and communicate medical diagnoses; prescribe and initiate medications from an approved formulary; and initiate, perform, and interpret a broad range of investigations, diagnostic procedures, and treatments from a defined list. Also inherent in the domains of practice of an ACNP are the roles of educator, consultant, researcher and leader (CACCN, 2003; CNA, 2002b; CNO, 1998; Mitchell et al., 1993; NPAO, 1998). For the purposes of this study, acute care was defined as the level of health care services that can only be provided in a secondary, tertiary or quaternary level care hospital. Medical conditions are characterized by a sudden onset or a sharp rise of severe symptoms, and a short course. Treatment is aimed at cure or prolongation of life and symptom management.

Based on the work of both van Manen (1997) and Benner (1994), this study employed the methods of phenomenology and hermeneutics and therefore was both descriptive and interpretive in nature. Hermeneutics has been described as the practice and theory of interpretation and understanding in human contexts (Chesla, 1995). It is said to be "(a) the attempt to understand the phenomena of the world as they are presented to us…, (b) the attempt to understand how it is we go about understanding the world as it is presented to us, and (c) the attempt to understand being itself" (Cohen, Kahn, & Steeves, 2000, p. 5). It is considered a reflective inquiry concerned with "our entire understanding of the world and thus … all the various forms in which this understanding manifests itself" (Gadamer, 1977, p. 18). The goal of hermeneutic phenomenology is to uncover commonalties and differences of what it means to be human, to discover all the possibilities for ways of being in this world as a collective whole (Heidegger, 1927/1962). Through attentiveness to language and traditions, "hermeneutics involves recognition of sameness, place, and belonging. …It is an acknowledgement that things come from somewhere; they are not simply fabricated" (Moules, 2002, p. 5). Essential to this goal is the belief that every human is completely shaped by the culture and traditions (including its language and symbolic activities) in which one is "thrown." Having no control over the "thrown-ness" of one's social environment, we all become one with our culture, and all of our behaviors and ways of being are consequently learned from our "*world*." We are *beings-in-the-world* (Heidegger).

Being-in-the-world, as understood from this hermeneutic phenomenological perspective, infers that human knowledge is relational, temporal, and contextual, as opposed to being objective, static, and independent of the questioner (Gadamer, 1960/1989). As argued by Charles Taylor (1971, 1985a, 1985b, 1985c), the range of human desires, feelings, emotions, and hence meanings, is bound up with the level and type of culture, which in turn is inseparable from the distinctions and categories marked by the language people speak. Taylor (1985c) asserted this is because language and its expressive dimension allows for three important things to get done. First, "we make articulations in language and hence bring to fuller and clearer consciousness what we formerly only had an implicit sense of. …Second, it puts things in public space, thereby constituting and shaping the kind of space in which we can share something *entre nous*.

…Third, it makes the discriminations that are foundational to human concerns, and hence opens us up to these concerns" (p. 256-263). As a consequence, "hermeneutic phenomenology is a philosophy of the personal, the individual, which we pursue against the background of an understanding of evasive character of the *logos* of *other*, the *whole*, the *communal*, or the *social*" (van Manen, 1997, p. 7), an understanding that takes place when one interprets and finds meaning in the language of another.

As proposed by Gadamer (1960/1989), the vehicle that facilitates this process is open and participatory dialogue. Understanding is participative, conversational, and dialogic for it is only in a dialogical encounter with what makes a claim upon us that we can open ourselves to risking and testing our preconceptions (Gadamer). "Meaning is negotiated mutually in the act of interpretation; it is not simply discovered" (Schwandt, 2000, p. 195). Gadamer described meaning as the process of "coming into being" and believed that it is achieved through a process of moving dialectically between a background of shared meaning (the whole) and a more finite focused experience within it (the part) through the continuous process of questioning (p. 363). van Manen (1997) identifies six research activities that facilitate this dialogical encounter, which were employed in a dynamic interplay throughout this inquiry: "(1) turning to the phenomenon which seriously interests us and commits us to the world; (2) investigating experience as we live it rather than as we conceptualize it; (3) reflecting on the essential themes which characterize the phenomenon; (4) describing the phenomenon through the art of writing and rewriting; (5) maintaining a strong and oriented [*nursing*][4] relation to the phenomenon; and (6) balancing the research context by considering parts and wholes" (pp. 30-31).

Commitment

Gadamer (1960/1989) argued that, since understanding always arises from within one's own horizon, there can be no non-positional understanding of anything. Understanding requires the engagement of our fore-structures (Heidegger, 1927/1962). This means one must bring one's preconceptions to the interpretation of a text and then risk those prejudices in the encounter with what is to be interpreted. This view can guide us to insights, which then lead to a revised view in the hopes that each revision will give a more prereflective account (Dreyfus, 1991). In other words, the researcher cannot be placed outside the problem he or she formulates, for it is a personal undertaking (Bergum, 1991).

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[4] I have replaced van Manen's word pedagogical with *nursing*, as my orientation to the research question is from a nursing discipline perspective. As noted by van Manen (1997), unless the researcher remains strong in her orientation, there will be many temptations to get side-tracked or to wander aimlessly (p. 33).

Investigating the Experience

In hermeneutic phenomenological inquiry, the object of research is both language and the individual user of the language (Cohen et al., 2000). Hermeneutic phenomenological research becomes both the source and object of the research itself (van Manen, 1997), situating experience within a dialectic between self and the world. There is no belief in the separation of subject and object. Therefore, conversations with ACNPs provided the majority of lived-experience descriptions. However, because human science meaning is multi-dimensional, multi-layered, and oft times ineffable (van Manen), communicating with various other sources of data facilitated the search for and expression of meaning. "As we develop a *conversational relation* with a certain notion that has captured our interest, we cannot ignore the insights of others who have already maintained a conversational relation with that same phenomenon" (van Manen, p. 75). Consequently, literary works (e.g., poetry, novels, plays), movies, songs, photography, and art works, along with an exploration of etymology and the philosophical and nursing literature became other information sources consulted throughout the process of hermeneutic phenomenological reflection.

The Participants. The goal of the study was not to oversimplify the complex world that affects the ways in which the ACNPs interpret their experiences but rather to broaden the variation of information. Therefore, four institutions from three provinces in the central and western regions of the country that had been employing for more than two years NPs who had graduated from university-based nursing programs with a NP focus were selected. Two of the institutions were large, quaternary adult/pediatric teaching hospitals, and another two were pediatric, quaternary teaching hospitals.

Lists of the names of those nurses in the ACNP role in the four institutions were accessed by various means. In one province, the list of licensed ACNPs is a public document and therefore was accessible through the professional nursing association. For the three other institutions, the ACNPs' names were accessed through the Departments of Human Resources with the facilitation of the Chief Nursing Executive, Professional Practice Leader, or Nursing Administrator. Letters explaining the study and requesting participation (Appendix A) were then distributed via intra-hospital mail or hospital electronic mail systems to each prospective participant, as per the directive of the institution.

All of the potential participants who expressed an interest in participating met the following criteria for inclusion in the study: (a) currently working in an ACNP role (i.e., had responsibilities that included, but were not necessarily limited to, the management of hospitalized acutely-ill patients); (b) working as an ACNP for a minimum of two years and (c) employed more than twenty hours per week in their ACNP position[5]; (d) graduated from a recognized university-based NP training program (undergraduate or graduate level)[6] ; and (e) had the ability to comfortably describe their feelings and experiences using the English language[7].

One of the tenets of hermeneutic phenomenological research is to see participants not in terms of groups of individual characteristics that are viewed as variables but as people who offer a picture of what it is like to be them as they make sense of their experiences (Cohen et al., 2000). As a consequence, it was essential that the participants be, not only knowledgeable, that is, have lived the experience of being an ACNP, but also articulate, patient with the process, reflective, and willing to present and re-present their own personal experiences with me through the sharing of their stories, thoughts, and feelings of what it means to be an ACNP (Morse & Field, 1995). Therefore, before asking the ACNPs to participate, each of them was informed that their individual experiences were of interest because they had so often been excluded in other research regarding the NP role. It was important to hear *from their point of view* what was important about their experience and life as an ACNP. Their willingness to recall and describe their experiences and to participate in the emerging interpretation were discussed on a one-on-one basis.

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[5] Given that we are constantly in the process of "composing a life" (Bateson, 1989) and that events, or time, are essential to experience, that is, "I am myself time" (Merleau-Ponty, 1945/1962, p. 421), these second and third criteria were established to ensure that the participants had had time to accumulate experiences as an ACNP, to make sense out of them, and to embody the experience of being an ACNP. How the participants have lived being ACNPs, which can only be experienced over time, was the interest of this hermeneutic phenomenological study.

[6] As previously identified the development of the NP position has varied widely in terms of qualifications, education, and titling. This fourth criterion seeks to avoid selecting those nurses who work in roles entitled NP but who have been trained through in-house programs or who have no training at all.

[7] Two of the target hospitals are designated bilingual institutions and employ nurses with French as their first language. However, I am not bilingual.

Twenty-six ACNPs volunteered to participate in the study. All but one had graduated from an acute care nurse practitioner program, while the one had been prepared as a primary care nurse practitioner. Six of the participants had initially been prepared at the graduate level to be CNSs and then had worked in this role prior to further advancing their education as ACNPs. Nine of the participants had received their basic nursing training from hospital or community college based diploma programs, while the remainder had attended university. Three also mentioned having completed another diploma or undergraduate degree prior to entering into nursing.

The participants in this study presented with a diversity of ages, nursing specialties and subspecialties, educational background, years of experience, and types of previous nursing experience. The ACNPs who volunteered came from neonatal, pediatric, and adult critical care units; adult and pediatric neurology, neurosurgery; oncology; cardiology and cardiovascular subspecialty services; and adult nephrology/dialysis, orthopedics, family medicine, gerontology, and subspecialty services within infection control. Male and female ACNPs participated. The diversity of the participants provided an opportunity to reveal the common ground that ACNPs share, regardless of background.

All but two of the ACNPs worked full time. Six of the participants had 10 or more years of experience in the role; 10 had between 5-9 years of experience; and 10 had less than 5. Only one had just the minimum required two years necessary to be a participant in the study. Total years of experience in nursing ranged from 14 to 35 years. However, having the most years of nursing experience did not necessarily mean that the participants were the most experienced as ACNPs. In fact, six participants with more than 20 years of total nursing experience had less than 5 years in the ACNP role, while three of the participants had spent more than 15 years of their 20 plus years of total nursing experience in the ACNP role.

The Conversations. Arrangements were made to meet at a private, quiet setting of the participant's choice (e.g., the participant's home, my lodgings, or a room within the institution but away from the patient care area). The term "conversations" rather than "interview" is chosen to describe the actual process that was used. Gadamer (1960/1989) describes conversation as "a process of coming to an understanding" (p.

385). "To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are oriented" (p. 367). The conversations began with general chitchat with the intent of establishing rapport and building trust. The study was explained once again (Appendix B) and any questions or concerns were addressed. As they agreed to continue the conversation, a written consent was then obtained (Appendix C). Once the ACNPs felt ready to talk about their experiences, audiotape recording began. Each conversation generally began with the prompt, "*Share with me a day in the life of you as an ACNP*," and proceeded gradually at the participant's own pace and on their direction to conversations concerning what drew them to the role, their education and learning, seminal influences that shaped them in the role, key relationships, accounts of what they found satisfying and dissatisfying about their work in the course of a day, real-life clinical decision-making, and visions of their future. The participants were encouraged to enrich or clarify their thoughts by sharing specific concrete stories of encounters in the work situation that explicated what they were attempting to describe (Bergum, 1991). Additional prompting was rarely needed. Indeed, many of them were circular in their thought processes, asking themselves questions as they spoke, such as, "*I wonder why I just said that*," and then exploring answers to their own questions. Each conversation ranged in length from 2 to 3 ½ hours.

Two conversations were held with the first three participants in the study. The purpose of the second, which took place two to six weeks following the first, was to explore further reflections about their experiences of being an ACNP that might have been generated following the first conversation, as well as to probe more deeply ideas that had been raised. However, it was noted that no new issues or themes were generated; rather thoughts that had been mentioned previously were reaffirmed by sharing additional stories. Therefore, second conversations were not deemed necessary unless the participants requested more time together. No one chose to accept this offer.

Immediately following each conversation, field notes were recorded and then later incorporated in the reflective journaling. Each conversation was transcribed into textual data by a transcriptionist. Transcripts were then verified against the audiotapes, not only for accuracy, but also to make notations of such things as changes in voice, emotion, significant pauses, laughter. This process also facilitated a further closeness and familiarity with the text and the identification of further ideas and questions, which were also incorporated in the reflective journaling. During the process of the study, impromptu discussions with NPs at conferences, along with chat room conversations on an advanced nursing practice list serve, provided additional insights and thoughts for reflection journaling.

Reflecting

Finding meaning in hermeneutic phenomenological inquiry involves moving from the field text, created by data collection, to a narrative text that is meant to stand alone for other readers (Ricoeur, 1973). In keeping with the philosophy of hermeneutic phenomenology, no definitive set of research rules for interpreting and presenting qualitative data were used (Gadamer, 1960/1989; Heidegger, 1927/1962; van Manen, 1997; Wolcott, 1994). However, generally speaking, three principal activities served to guide the uncovering of hidden meanings within the ACNPs' experiences and to derive the structures of meaning or themes as recommended by van Manen:(1) the sententious or holistic approach, (2) the selective or highlighting approach, and (3) the detailed, line-by-line approach (p. 92-93). In short, the thematic threadss of the lived experience were uncovered by examining words, phrases, sentences, textural excerpts, and each transcript as a whole.

The isolated themes were then reflectively transformed into "more phenomenologically sensitive paragraphs" (van Manen, 1997, p. 95), using the technique of "varying the examples" to demonstrate the "invariant" aspects of the phenomenon as it came into view (p. 121). Other sources of lived experience material were woven into the reflective text within this process.

A reflective journal and audio recordings were used to capture reflections on the conservations with the participants. Various readings, films, art work, personal experiences, the evolving interpretive analysis, and so on were also included. All of these entries were useful as triggers for further, deeper reflection.

Writing

Unequivocally, the very act of writing down the results of the analysis of the text was an integral part of the process of hermeneutic phenomenological reflection and resulted in the continuous emergence of new insights. Writing and re-writing and re-writing, what van Manen (1997) has described as the activity of doing phenomenology, did not enter the research process as a final step, but rather served as an intimate component of uncovering meaning. van Manen wrote that "to write means to create signifying relations and the pattern of meaningful relations condense into a discursive whole" (p. 132). As van Manen (2006) has repeatedly argued: "It is precisely in the process of writing that the data of the research are gained as well as interpreted and the fundamental nature of the research questions is perceived" (p. 715). In short, the many re-writes undertaken in this study mediated reflection and action (van Manen, 1997, 2002a). Writing is the method. It is an interpretive act, a creative act, a personal act. A verse by Lu Ji (261-203), cited in Barnstone and Ping (1996), poignantly describes the process of writing in hermeneutic inquiry:

> Writing is a joy – so saints and scholars all pursue it.
> A writer makes a new life in the void, knocks on silence to make a sound,
> binds space and time on a sheet of silk and pours out a river from an inch-sized heart.
> As words give birth to words and thoughts arouse deeper thoughts,
> they smell like flowers giving off scent, spread like green leaves in spring,
> a long wind comes, wilts into a tornado of ideas, and
> clouds rise from the writing-brush forest. (p. 10)

The ACNPs' stories and comments have been used extensively throughout the writing. Following Benner's (1984) recommendation, the materials have, for the most part, been left in the language in which they were delivered, although for ease of reading the inevitable "ums", "uhs", and "you knows" that occur during conversations have been omitted. In most cases the ACNPs' stories have been left intact because fragmenting the experiences "distorts that which it seeks to describe" (Anderson, 1991, p. 35). It is important to note, however, that several quotes have been modified to protect anonymity, although no substantial change was made in cited dialogue. This primarily involved a change in words involving a gender designation or institutional citing.

Ethical Considerations

To assure protection of the rights of the participants, permission to conduct the study was sought from all appropriate research/ethics committees at each institution. To ensure the participant's' right to informed consent, letters explaining the study and requesting participation were distributed via mail to each prospective participant (Appendix A). This information was re-explained when the prospective participants first contacted me to indicate their interest, and then again prior to the signing of the written consent (Appendix B) at the time of the first conversation.

Each participant's name was removed and replaced with a pseudonym to protect his or her identity. The participants were informed that excerpts and quotations from their conversations might be included in the final text for the purpose of providing examples or enriching the text, but that in the event that names were associated with this information, pseudonyms would be used and all identifying information, such as institutional names, would be deleted and/or modified. In fact, to facilitate confidentiality, no names have been attributed to specific ACNPs (or patients and families) in the examples used in these final writings. Gender pronouns (he/she) have also been used interchangeably throughout the writings to help protect the participants' identities. A typist, who did not know the participants, assisted with transcription. The tapes, transcripts, and journaling notes were maintained in a locked drawer in my home.

The participants were assured that their participation in the inquiry was entirely voluntary and that they could withdraw from it at any time without adverse consequences. They needed only inform me by electronic mail or by phone. No explanation would be necessary, nor would anyone know about their decision. Any information that had been shared would be destroyed at that time, if they wished. No one withdrew.

As the nature of the study relates to the intimate experiences of being an ACNP, being ethically sensitive to the participants' experiences was essential at all times. The participants understood that if warranted by the situation, the conversations would be terminated and assistance would be offered with making a connection to the institution's Employee Assistance Program. On several occasions, participants' shared emotive stories that resulted in our shedding of tears together. However, after a brief period of silence and sharing, the participants eagerly returned themselves to their stories, fully cognizant of the choice to stop the dialogue at any time. Although there were no anticipated benefits from their participation in this study, some participants stated that they found it beneficial to have the opportunity to share their stories about being an ACNP. Some stated at the time or wrote later that they appreciated the chance to reflect on their practice and ultimately it affirmed their choice of becoming an ACNP.

> After you left I kind of went "Whew." I was tired and I didn't feel tired at the time, but later I kind of went, "oooh." But, you know, I enjoyed it. It was nice to reflect. And you could tell I enjoyed talking a bit. Nursing stuff is always fun to talk about, so it was very enjoyable for me.

Evaluative Criteria

Hermeneutic phenomenological research requires ways for assuring standards of rigor that are different from those used in quantitative research studies (Lincoln & Guba, 2000; Scheurich, 1997; Wolcott, 1994). Kahn (1993) argued that the need for the researcher to account for relationships is at the heart of the hermeneutic research process. Consequently evaluating phenomenological inquiry needs to be grounded in a language of relationships - the relationship of the researcher and participants, the researcher's relationship with the text, and the relationship of the researcher with the readers. As a result, criteria for establishing trustworthiness based on relational ethics formed the basis for the evaluation of this hermeneutic phenomenological inquiry. The following describes how the criteria were applied throughout the research process.

Meleis (1996) wrote that knowledge without a context leads to marginalization of populations under study and to stereotyping of groups. Consequently, the complexity of the participants' reality was emphasized and explicated, thereby recognizing the participants' everyday experiences as inextricably connected to the larger political, social, and economic environment. In other words, to be engaged in the language of ethics-in-action, the following questions were constantly asked: "Have I connected the 'voices' and 'stories' of individuals back to the set of historic, structural, and economic relations in which they are situated?" (Fine, Weiss, Weseen, & Wong, 2000, p. 126). "What are the traditions in which we participate that are relevant to the phenomenon under study?" (Gadamer, 1960/1989)

Another way in which hermeneutic research should be evaluated is "the extent to which the scholarly interpretations demonstrate critical understanding of preferred communication styles for the research participants and their communities, including the most congruent design for the population's communication style" (Meleis, 1996, p. 11). Wolcott (1994) reflected a similar stance when he stated that he had tried to record as accurately as possible, and in precisely the participants' words, reporting their comments fully, even when he did not know exactly what they meant. Therefore, this understanding of communication style is demonstrated in the final form in which the research findings have been shared. At the same time, there has been an endeavor to create vivid text through the use of concrete description, examples, quotations, metaphors, and other relevant lived experience found in literary sources and additional ontological works.

Trustworthiness must also be established by evidence that the researcher is cognizant of the power differential and acknowledge levels of hierarchical power (Meleis, 1996). In order to establish a more horizontal relationship with the participants and to develop shared authority and shared ownership of the data, the developing manuscripts were shared with some of the ACNPs, thus checking for "narrowness of vision, prejudices, and focus" (Moules, 2002, p. 32), that is, to ensure that the generative nature of interpretation had been honored and kept in play. Similarly, a presentation of preliminary findings to a group of ACNPs served as an opportunity to evaluate the interpretive work, particularly on its ability to open up questions and to elicit "the phenomenological nod" (van Manen, 1997). However, "it is significant to recall that the topic is *not* the participants, nor should the writing be a *portrait* of the participants" (Moules, p. 28). "It is neither mere particularity, nor sheer universality" (van Manen, 1997, p. 23).

CHAPTER THREE

THE TRANSFORMATIONAL JOURNEY OF ACUTE CARE NURSE PRACTITIONERS

The Journey

Steps slowed
Head bent low
But still along the way

Hopelessness pervaded
Doubts persuaded
But still along the way

Time and again
Fear shouted "You're no man"
But still along the way

Sweat and tears
Poured through years
But still along the way

Stumbling, crawling
Crying out, calling
But still along the way

Searching blindly
For destination and finally
Finding it one glorious day
~ J. C. Justice (2004a)

Acute-care nurse practitioners are self-discovered in their own journey; they are not made or invented by others. ~ J. Rashotte

An understanding of the transformational journey of acute care nurse practitioners begins here with three stories[8] . The first story begins with Paula. She received a Bachelor of Science degree, majoring in anatomy and physiology with the intention of going to work in a research laboratory. But the field of health care had always been in the back of her mind, so she continued in school and trained to be a Respiratory Therapist. It just so happened that in her first job, she spent a great deal of time attending to patients in a critical care environment where she frequently observed that the nurses appeared to take every opportunity to involve their patients or families in the decision-making process. She was impressed that they always seemed to be concerned about what was right and best for each particular patient and family, even when it meant being in conflict with other health care team members. Paula reconsidered what it meant to provide health care and realized that what she envisioned for her career was more than being involved with the technical aspects of the patients' care. She acknowledged that she was drawn to the philosophy of nursing, the idea of treating the person as a whole, in mind-body-spirit, and soon thereafter found herself pursuing a career as a nurse. She has worked in a variety of settings and nursing positions, most currently having pioneered the new nursing role of acute care nurse practitioner in oncology. Paula loves the career path that she has chosen and when asked if she has ever regretted this choice, she quickly remarked that she "wouldn't trade in her job for all the tea in China."

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[8] These particular three stories are the union of the many stories shared by the participants in this study; they do not relate to one particular ACNP, although they are all the ACNPs.

Unlike Paula, Susan was interested in nursing from an early age. As a young child, she loved to play first aid, applying the bandages and trying to make the hurt go away. She attended nursing school right out of high school and, having developed a passion for the care of babies, she secured a job in a neonatal intensive care unit immediately upon graduation. Over the years, she has held a variety of neonatal nursing positions in transport, management, and education. She imagines that her nursing career is one that continually offers learning and growth and options that are endless. Currently Susan is a neonatal nurse practitioner, a role that she too pioneered.

The final story is about Stephen. His mother was a public health nurse in India and at a young age, Stephen often accompanied her on home visits or to the community clinics, to act as her translator. He witnessed up close the process of caring for patients while also developing relationships with them, all the while carrying a high degree of autonomy and responsibility in the nursing role. For a time, Stephen considered becoming a physician. But after various volunteer experiences in acute-care settings and in-depth conversations with various health professionals, he realized that what he envisioned for his career was not just related to providing diagnoses and treatments. He wanted to empower patients through health education, advocacy, health promotion, and counseling, all aspects of a role that best fit with the nursing role he had seen his mother perform. He received a bachelor of nursing degree and after graduation worked as a nurse in Ethiopia and South America. Stephen currently is an acute care nurse practitioner, a role he pioneered in an infectious diseases subspecialty.

What do the stories of Paula, Susan, and Stephen all have in common? At first glance, the stories concern how each person has arrived at nursing via different routes but in the end they all become ACNPs. But if one looks more deeply, these stories also reveal that these individuals have been on a journey. The nature of being an ACNP is embedded in a transformational journey, the journey of becoming acute-care nurse practitioners in the quest for the "perfect fit" in nursing. The journey is a search for "more" in their lived experiences as nurses, that is, a journey toward personal fulfillment in their nursing practice, a quest to discover their true selves as nurses, the treasure that is who they really desire to be as nurses.

What is the journey that must be taken? What price is to be paid? What sacrifices are required? If there is treasure to be found, where does it lie, and how do those nurses who venture forth get there? Certainly, the classic literature - both Western and non-Western - is replete with the journey motif. Virgil's *Aeneid*, Bunyan's *Pilgrim's Progress*, Dante's *Divine Comedy*, Lewis Carroll's *Alice's Adventures in Wonderland*, Homer's *Iliad and Odyssey*, Shakespeare's *The Tempest*, Swift's *Gulliver's Travels*, Coehlo's *The Alchemist*, and Tolkien's trilogy, *the Lord of the Rings*, to name just a few, speak to the journey we all experience as being human, and can help us understand the ACNPs' journey.

One of the most famous journeys in classical literature is described in Plato's *Allegory of the Cave*, which appears in Book VII of the *Republic* (1984). The story tells of a prisoner who breaks free from his chains inside a dark cave, where his knowledge of the world has come only from the shadows of images cast by the firelight on the cave's wall, and makes his way out into an unknown world filled with sunlight and real objects. As the prisoner comes to recognize the world beyond the cave, he denounces his allegiance to shadowy images and embraces the eternal forms of the Beautiful and the Good, ultimately seeing himself in these images. Simplistically, Plato explains that to leave one's cave is a difficult and scary process, for it means defying social influences and known ways of being. Most of us have absolutely no interest in the notion of struggle and instead aim for the convenience and security of our routines. We are entranced by the comforts of the home, of the cave. But just because the cave, even a gilded one, has been our "home" does not mean that we should stay there all the time. The cave can become fetid if we never break free and venture forth. Whole areas of ourselves can atrophy if we do not take responsibility to pursue our aspirations. But Plato also warns that upon one's return to the cave, each of us is faced with the challenge of explaining that which we have seen and experienced in a new way to those who only want to see what they have known in the cave.

In another classic, *The Lord of the Rings*, Tolkien (1955/1968) tells the story of one hobbit's reluctant journey out of his cave, a hobbit Shire, in a quest to save the world by destroying the ring of power. Throughout the course of his journey, the hobbit becomes increasingly burdened as a consequence of leaving behind his worldly possessions, being confronted with mortal dangers, and gradually comprehending the role he might play in the ring's destruction. As he and his companion journey further and further from the comfortable Shire, they suffer physical and psychological wounds, wounds that with each stage of healing make them more confident and greater risk takers. Both of these stories speak of the basic motif of the universal journey – leaving one condition and finding the source of life that brings one forth into a richer condition.

In one way or another, all of these classic stories share a common narrative of a journey away from what is comfortable and secure, away from the predictable habits and commonsense wisdom of our routine, everyday lives. In *Moby-Dick*, Melville (1851/1992) speaks to the journey as the possibility of self and Others being realized in a much fuller sense; the journey is about the ability to change and adapt in a more meaningful way. Melville suggests that there are those of us who are "landsman" who only "water-gaze," leaning against the rails of peers, striving to catch a glimpse of life beyond land, beyond safe harbors, caught up in the desire to begin a new journey. But in the end, we chose to stay with what is comfortable and safe. Others, however, have deep desires and needs for something more than what their lives or work have to offer. Consequently, they orient themselves toward change, toward striving after something more, strivings which are an expression of what Hegel (1807/1971) called "yearnings" – yearnings toward freedom, equity, community, and recognition. They long to set sail, to embark on an adventure and experience the untried. It seems that staying moored to the familiar and comfortable is limiting.

The ability of these writings to express our own lived experiences of being on a journey helps us to understand that, although a journey can be about a movement from one place to another, not all journeys are movements in space. Although many are physical, many others are intellectual, psychological, spiritual, or philosophical. Moreover, they help us to appreciate that there is more to a journey than reaching one's destination. As Tolkien (1955/1968) pointed out in the *Fellowship of the Ring*, the first book of the *Lord of the Rings* trilogy, "Not all those who wander are lost" (p. 278). Ultimately, journeys are all about leaving what is known, feeling increasingly burdened when faced with uncertainty, facing fears and confronting the challenges encountered, and then forging new self-identities as one lets go of old ways of being and belonging. Journeys involve the timeless cycle of going out and returning: a leave taking, finding fulfillment, the homecoming process. In this way, a journey becomes existential and transformative. It combines a journey of going upward and outward with a journey of going downward and inward, the seeking out as well as the descent into the void. As David Suzuki (1988) wrote in *Metamorphosis*, an autobiographical account of his life's journey:

> My life in retrospect has been marked by a series of transformations. It's interesting to note that in the rest of the biological world, profound change in the lives of many organisms is a natural and necessary part of their development. Often these changes involve dramatic transitions in physical makeup, behavior and habitat. This process is called metamorphosis. (p. 6-7)

Following in Heidegger's footsteps, philosopher Charles Taylor (1989) similarly argued, "My sense of myself is of a being who is growing and becoming... It is also of a being who grows and becomes. I can only know myself through the history of my maturations and regressions, over-comings and defeats" (p. 50).

Becoming an ACNP involves a journey from one mode of being as a nurse to another: from a nurse without permission to engage in a set of activities previously authorized only to physicians to a nurse legally engaged in these activities. At first glance, this appears fairly simple. However, attention to the journey itself reveals elements of a transformative process embedded in an experience of dialectic. Indeed, the ACNPs' journey is a journey directed *outwardly* into the world and a journey directed *inwardly* into the self. The former – the journey without – is a series of both triumphs and conflicts encountered along the way. The latter – the journey within – is a series of internal struggles within oneself, culminating in a union with the forces against which the ACNPs struggle. For example, on the one hand, ACNPs are not satisfied with the traditional model in which they are required to deliver nursing care in the acute care setting. They do not want to embody Homer's Penelope, waiting patiently for something more, endlessly weaving and unweaving the same pattern. They need to embark on their own journey in order to find a way to fully embrace their potential, all the while valuing themselves as nurses. On the other hand, there is the constant danger of seeing the activities of diagnosing and prescribing as the major identifying characteristics of being an ACNP, and indeed the primary reason for the role's existence. They do not want to be seen in this new nurse practitioner role as physician substitutes, simply an advanced model of handmaidens in the physician-dominated health care profession. Consequently, theirs is a very important journey toward being a fully integrated, balanced, and whole person within a new nursing role in the acute health care system.

The ACNPs' journey is not linear or unidirectional. A linear view does not account for the intertwining, dynamic, and iterative nature of the learning, growing, doing, struggling, and accommodating, within relationships that are different from that which has been previously known. A linear view does not accommodate the depth of change that such a journey entails. New experiences reach back to earlier experiences which are now understood in a different way. Similarly, experiences earlier in their journey reach forward to envelop present experiences with transformed significance. These transformations take linear time but involve change that is deep, complex, sometimes dramatic, although most often are more of an insidious and cumulative nature that result from many ordinary, day-to-day experiences. The transformative journey takes longer for some than for others, and varies in intensity and depth. They begin to feel their dependence and vulnerability in new ways and wonder about their abilities. As a result, some feel ambivalent about the magnitude of change in their lives.

The journey is also not a definitive or fixed experience. Rather, the journey for some may be a never ending process, changing and developing with various events they experience. Additionally, movements through the journey do not happen separately; they often go on at the same time, with endings occurring in one movement, beginnings happening in another. But ultimately, the transformative journey opens up previously unimagined new selves, new areas of responsibility, fatigue, anxiety, ambivalence, satisfaction, and joy. Just as the hobbits in the *Lord of the Rings* or the prisoner in Plato's *Allegory of the Cave* are who they are as a result of the wounding and healing processes they undergo, ACNPs too learn to let go of their old ways of being and belonging, and as a result, their journey becomes existential. Once this transformation occurs, their self-conceptions become harmonized with their duties, and they fulfill the Nietzschean charge to "become who you are." Viewed from a Hegelian perspective, this journey requires a circular perspective. It has no beginning and no end; nothing is excluded, everything finds its place and is understood as an integral aspect of a whole.

The journey begins with the nurses' desire to look for something more in who they can be as nurses and what more they can offer to others. What they have is no longer enough and they begin to awaken to an inner stirring that says they want more. For some, this is a slow, subtle, and deliberate process that appears to be in contradiction to the harmony of the every day world around them. "I should be happy or satisfied with what I have now" is a familiar voice, which translated means "I am not satisfied or happy now." But underlying all the verbal tug-of-war, awareness develops to go beyond the known. For others, the call comes in a more dramatic fashion, usually involving a significant upset of the status quo in their lives: being laid off, an illness, a loss. These are "wake up calls" to pay attention to the inner voice that wants to be heard. But this is no easy accomplishment. This call is heard at no specific age or time but occurs when there is the perception that what they are doing no longer fits with what they want to do and who they want to be as nurses. Perhaps it is not unlike that sense we have that the clothes we are wearing no longer seem to fit, yet all the while we keep pulling and tugging on the end of them. This beginning requires either the seizing of an opportunity or the creation of one, with the ACNP role perceived as the possibility of offering "the perfect fit." Searching for the "perfect fit" is all about *Being Called to Be More*, the search for *being more connected*, *more in control*, *more visible*, *more challenged*, and *being able to make more of a difference* in one's nursing practice. Heeding the call by creating or seizing opportunities initiates a transformational journey from a time of *being adrift* through *being ACNPs* and *being pulled to be more* to *being more*.

Certainly the journey is fraught with struggles, tensions, and battles, as well as places and persons that both facilitate and thwart the achievement of their goals, reminiscent of Homer's *Iliad and Odyssey*. The journeys are always fraught with numerous trials and tribulations in the classic literature. Once the protagonist leaves the safety of the cave and goes in search of that for which he is looking, along the way he meet ogres who trick him into going down dead ends, adversaries who challenge his cunning and resolve, and obstacles that he must avoid, circumscribe, or overcome. Often he is required to put on his armor, pick up his sword, and go into battle. He needs a lot of thread[9], and all his wits and stamina about him to make the journey. There are constant reminders that the protagonist will encounter obstructions along the way both in the outer world as well as in the inner world.

But journeys are never accomplished without the help of others. External supports become the port in the storm that helps us feel secure when we are plunged into the depths of the unknown. In the *Iliad* and *Odyssey*, Homer (1996) introduces the mythological figures Athena and Chiron. In various guises and disguises, Athena safely guides Odysseus on his treacherous journey both into battle and on his return home. Sometimes she is the inventor, then the teacher, or the warrior, and even the protector. Recognizing Odysseus's strengths, Athena offers him opportunities, knowledge, skill, and political acumen, thus instilling in him a sense of confidence that he can make the treacherous journey. Chiron, known for his wisdom, justice and healing acumen, mentors Achilles and Hercules in the art of medicine. Later, these disciples spread Chiron's teachings of healing far and wide. Even Thoreau (1854/1995) acknowledged his need for a neighbor to lend him an axe, in *Walden*, his journey of living a solitary life in commune with nature. As Goethe[10] so eloquently opined: "At the moment of commitment the universe conspires to assist you."

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[9] This is a reference to Ariadne's thread in Greek mythology.

In the same way, ACNPs' stories are replete with tyrants that appear on their journey to test their endurance and their decisiveness, while dragons guard the treasure, telling them they do not want them to succeed. Coworkers affront them, licensing boards change their requirements. Physicians sabotage them, all the while telling them they are capable of doing anything they set their minds to, as long as they do what *they* want them to do. Validation is seldom forthcoming. ACNPs' stories also tell of encounters with the forces of their own self-doubts, indecisiveness, paralysis, and fears. Yet somewhere in their history are stories of those who inspire and support them in their journey to becoming ACNPs.

Saying yes to the journey means facing the first struggle – fear of commitment. Commitment to the journey is quite sobering. In answering the call to "leave the cave", all must step into the chilly, uncertain waters of the unknown and enter into the area of risk. The reality of the journey becomes jarring. ACNPs go through an in-between time where they are required to let go of the old ways of being and the old identity others have of them. At the same time they must learn new ways of thinking, acting, and relating to their nursing colleagues, the physicians, patients, and families in their clinical practice. This in-between time is both an ending and a beginning, an intensely emotional, even painful time, a time in which ACNPs feel out of sync with themselves. Sincere questioning begins. "Am I really up to this journey?" "What is this all for? What have I lost? Where is the nurse in what it is I do?" This in-between time is a time of living with the polarization of opposites, that is, nursing versus medicine, nurse versus physician substitute. This psychosocial and philosophical no-man's-land between an old and new reality is experienced as being in limbo between the old sense of identity and the new emerging one. The old way of being seems to be gone but the new way of being does not yet feel comfortable. It is a kind of emotional wilderness, a time when it is not clear who one is or where one belongs. Everything feels very dark and close. Feelings of worthlessness, confusion, and weakness abound. This time in the journey, a time that is entirely focused on the clinical component of ACNP practice, is called *Being Adrift*. This time is experienced as *being disconnected, being uncertain, and being lost*. However, *Being Adrift* is not only a dangerous time but an opportune time, a time of enduring, of *staying afloat*. *Being lost* is an essential part of the journey for it is a time in which ACNPs develop into who they need to be. It provides them with the opportunity to be renewed and revitalized. It is the well-spring of the new beginnings for which they have been searching.

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[10] This quotation has been attributed to Goethe, from a free translation of *Faust*, lines 214-230 by John Anster. However, The Goethe Society of North America has reported that the quote in fact came from W. H. Murray in *The Scottish Himalaya Expedition*, 1951, having understood Goethe's couplets - "Whatever you can do or dream you can, begin it. Boldness has genius, power and magic in it! - in this way during his own journey. Retrieved July 14, 2006 from http://www.goethesociety.org/pages/quotescom.html

Through time, experience, and dialectic engagement, ACNPs gradually journey through this period of *Being Adrift* and an inner transformation begins to take place. Having faced frightening places within themselves as ACNPs and having overcome their fears, a new energy begins to enter into places formerly occupied by the heavy burden or struggle. A feeling of inner security emerges from *being competent, confident, and comfortable* in their performance of the various elements of their clinical practice, which opens the way *for being committed, connected*, *and content* and ACNPs ultimately experience the feeling of *Being an Acute Care Nurse Practitioner*. A new sense of freedom and exhilaration is experienced, along with a sense of satisfaction with the discovery of being more. The various aspects of both medical and nursing practices are gradually brought together in such a way that they are no longer perceived as mutually exclusive. On the contrary, they are two constituents intrinsic to who ACNPs are and how they see themselves and how they are seen by others. ACNPs slowly and subtly integrate the medical knowledge and skills with the nursing aspects of themselves. Rather than resisting the tension created by these two constitutive practices, they embrace it and learn the delicate balance of combining both to work toward the larger quest of making more of a difference in the lives of their patients and families. This complementarity reflects an inherent unified duality, a convergence that enables them to make more of the type of difference they are wishing to make in their practice as well as enabling the possibilities for being more of who they desire to be. A focus on the integration and the resulting awareness of their interdependence results in the emergence of a new viable identity and a new sense of belonging, one that is grounded in their clinical practice.

However, the journey is not yet finished. Plato's *Allegory of the Cave* reveals that there is likely to be some struggles when the individual returns to the world of ordinary time. For some the return home is the most difficult part of the journey. New joyful sensations gradually become taken-for-granted and ACNPs experience new tensions that arise from the changing drift in internally or externally-driven performance expectations in the other dimensions of their role as advanced practice nurses. This time of their journey, *Being Pulled to Be More*, is once again experienced as a time of living with a polarization of opposites. *Being Pulled to Be More* is experienced by ACNPs as *being a wearer of two hats*, that is, wearing the "CNS hat" (education, leadership, research) versus wearing the "NP hat" (direct clinical practice); a time of living with two identities. Time is experienced as being diverted from one role to another; the direct practice role sacrificed to the other domains of practice, or conversely, the other domains of practice must be sacrificed at the expense of time spent in direct practice. For some, this polarization results from a resistance to engage in all the various domains of advanced practice when the search for "more" and the "perfect fit" has been personally achieved in the direct practice domain. For others, the polarization results from a lack of knowledge or skill in how to perform in these domains, yet all the while the call to find the "perfect fit, to experience "more," remains only partially discovered.

Some ACNPs continue their journey through this time of *Being Pulled to Be More* and, once again, with new opportunities for learning and an ongoing dialectic engagement, they live the experience of *Being More*. In due course, they undergo another inner transformation, gradually unifying the direct practice, education, research, and leadership domains of the advanced nursing practice role, in such a way that increasing the level of participation in any one domain of the practice does not dispense with any of the others, but on the contrary, increases the requirements of the others. During this time of *being more* as experienced in *being an advanced practitioner*, all domains of the practice are viewed as inseparable and mutually constitutive, whose complementarity gives the ACNP role its richness and dynamism. Ultimately, the unification becomes how some ACNPs identify themselves and how they are seen by others in their communities of practice. It is in this time in their journey that the ACNPs find a greater sense of personal fulfillment as nurses through their opportunities to make more of a diverse and broader difference to their patients, families, and the nursing profession and to discover more of their own possibilities for being who they desire to be.

Despite being burdened by the struggle embedded in politics and history, ACNPs each eventually navigate their own course as they journey toward self-knowledge, personal transformation, and authentic living as a nurse. Consequently, what ACNPs experience on their journey is an odyssey of a lived journey of learning – learning to find a new place where they feel they belong, learning to engage in and contribute to their communities of practice in a new way, and learning to inhabit a new identity, all of which are part of the quest for finding more, searching for the perfect fit. All the while, this lived journey of becoming an ACNP is one that necessarily occurs in the context of their lived experience of participation in a world in which ACNPs are currently pioneers.

Being Pioneers: The Context for the ACNPs' Journey

> To believe in something not yet proved and to underwrite it with our lives; it is the only way we can leave the future open.
>
> ~ Lillian Smith cited in Ladewig & Raaum (1999)

> When I went into the NP program, I didn't have a clue. I went into the program blind, totally blind. The whole program was barely one page when it was posted, saying that they were looking at recruiting people. But nothing was clear. ...And I think the part of pioneering something new, something that we had no idea of what was going to happen, was a definite challenge; being able to expand the role in nursing was something that was interesting. ...And it was like going on a roller coaster, but in the dark because with some of those rides you don't know what's coming next. And they're a very scary thrill ride, but the fact that you're in the dark makes it that much more fun. But then when the challenge became more obvious as I went through it, I had to actually rethink about it once I knew what it was.

Most nurses traverse paths that have already been well trodden by numerous others before them. They are seldom faced with charting new courses in foreign waters, discovering new worlds, or creating new roles. However, those currently in the ACNP role in Canada are pioneers. They are what Sheehy (1995) has described as the phenomenon of being "pacesetters."

> And the thrust at the [hospital] at that time was to phase out the CNS role, to have the NP role, which started, now I guess maybe about ten years ago at [hospital]. And the role started because there was a shortage of residents. And then eventually people saw that NPs in an expert scope of practice with a specific and a well defined patient population, that that role could take the burden off the physicians. I'm not sure that the role was ever really thought out as what the benefits could be for the patients but nursing then took that opportunity to try and articulate that. So I was in a role that was a clinical nurse specialist role that was going to be a nurse practitioner role. But nobody really knew what that was going to look like. So I really led that process of creating a vision and developing a role and really had wonderful buy in.

Pioneer, traced back to its medieval Latin origins, comes from the word *pedo(n)* or *peon*, meaning to be a foot-soldier. The Old French word *pio(u)ner* retained this notion but also carried the meanings – to dig, to excavate, and to mine. Curiously, the Anglo-Norman word *poun* originated from the same Latin source, which gradually found its way into our current usage as the word *pawn* (Barnhart, 1988). This word, commonly associated with the game of chess, is understood to be a person or thing used by another for his or her own purposes. Its descendants, Portuguese *peão* and French *pion*, both mean 'footman' or 'servant' as well as 'foot soldier.' The English borrowing peon was first used in India in these same senses in the 17th century. Two centuries later Englishmen in Spanish America called the working classes peons.

In a military sense, a pioneer is a member of an infantry group who marched ahead of an army preparing the way for the main body of troops by excavation or construction. Implied in the meaning of the word in this latter usage, is a sense of being an explorer, a navigator of uncharted waters. Pioneer embodies the notions of hard physical labor, the creation of a map that others will more easily follow, the engagement in numerous struggles and battles, and the potential for human loss along the way. While the word has the potential for carrying the possibility of ACNPs being viewed as least valuable in the game of health care and thus easily discarded by those in position of power, as importantly and yet more easily forgotten, the word pioneer embodies the notion of something being mined and thus unconcealing that which was previously hidden. Being a pioneer embodies the notion of rich stores and abundant sources of potential rewards for the ACNPs themselves, the profession of nursing, the health care system as a whole, and the patients and families for whom they care.

Being pioneers means ACNPs leave their safe harbors without maps and navigational charts and no straight paths to follow. Perhaps it is best described by Arturo Pérez-Reverte (2001) in his novel *The Nautical Chart*.

> There are no handbooks on lighthouses and perils and signals for navigating on land. No prescribed routes, no updated charts, no outlines of shoals measured in feet or fathoms, no markers at such and such a cape, no red, green, or yellow buoys, no conventions for boarding, no clear horizons for calculating latitude. (p. 19)

Of all the bewildering things about pioneering a new role, the absence of landmarks, or what Etienne Wenger (1998) has termed reifications, is one of the most challenging, frustrating, and sometimes, even disheartening. Just as the wilderness pioneers experienced the absence of human landmarks – "roads that were but faint tracks in the grass, and the fields scarcely noticeable" (Cather, 1913/1997) – so too do ACNP pioneers face a new world that lacks the landmarks of a community of practice. This new role within the traditional world of health care is an enigma not yet captured and tamed in the form of social structures that have been historically tried and tested and then gradually sanctioned and reified as true. Canadian ACNPs as a collective in this role have yet to develop their own practices, routines, rituals, artifacts, symbols, conventions, stories, and histories that bind them together across time and space in such a way that there is a common sense of belonging and identity.

There is much as nurses that is taken for granted as practicing within the profession, the particular specialties and subspecialties of practice, and even within the particular jobs held within the institutions and units of work. As nurses entering any number of nursing subspecialties within acute care, they undergo a process of learning and of knowing about the nature of these roles, and hence who they are, all because of the various well-established communities of practice. For example, they are able to create meaning about their experiences as bedside nurses in pediatric critical care because there is already a way of talking collectively about the nature of this role.

Wenger (1998) points out that we learn from the collective about the practices, or the shared historical and social resources, frameworks, and perspectives of the role, through this language. It is this way of talking that enables us "to sustain mutual engagement in action" (p. 5). In fact, we even take for granted the way we learn and know about which enterprises within our work are deemed worthy of pursuit, or how and when our participation in those activities are recognized as competent and trustworthy by the community. That is, we learn to know when we have met the criteria that qualify us to belong. Ultimately, we take for granted that how we have changed and how we have learned and come to know who it is we are, even with our own personally created histories as nurses, has occurred within the context of our communities of practice. Clearly, nurses, as pioneers of the ACNP role, leave behind a world that has provided, albeit forgotten, the elements of learning and knowing, that is, meaning, practice, community, and identity (Wenger). As pioneers, they leave behind well-established communities of practice in order to build a new community of practice for the ACNP role. Typically this is an endeavor they face alone in their areas of work, an additional challenge to be overcome in their quest for a viable identity and a sense of belonging.

This does not mean that ACNPs develop or preserve a sense of themselves in isolation of other communities of practice with whom they work. We all belong to several communities of practice at any given time and work alongside other communities of practice, a few with whom we may even share some goals and actions. In order to fulfill the requirements of their employers and patients – no matter how disparate and vague –

ACNPs need to create a practice to do what needs to be done with the set of people and communities they work with on a day-to-day basis. As Wenger (1998) so aptly pointed out, "in spite of curriculum, discipline, and exhortation, the learning that is most personally transformative turns out to be the learning that involves membership in these communities of practice" (p. 6). In the case of pioneering ACNPs, their experiences of dealing with the various agendas of the multiple communities of practice, as well as those of their patients, shape their journey. Both the eye-opening character of the novelty or foreignness of being ACNPs and the remembrance of the taken-for-granted familiarity of the elements of the old community of practice result in many of the struggles, tensions, and battles that ACNPs face in their transformation journey.

CHAPTER FOUR

BEING CALLED TO BE MORE

> *Come, my friend,*
> *'Tis not too late to see a newer world.*
> *Push off, and sitting well in order smite*
> *The sounding furrows; for my purpose holds to*
> *sail beyond the sunset.*
> ~ Alfred Lord Tennyson, *Ulysses*, (1842/2001, p. 88)

Why do nurses decide to become ACNPs? What initiates or precipitates their journey? What are they looking for? What might they be running away from or toward? What more do they want? How do nurses know when to start out on their journey? These questions are of particular importance when one considers that the ACNP role is new in Canada and therefore ACNPS are pioneers. In the classic novel, *O Pioneers*, a tale of the epic labors of the Swedish and Bohemian pioneers of the Nebraska prairies, Willa Cather (1913/1997) wrote: “a pioneer should have imagination, should be able to enjoy the idea of things more than the things themselves” (p. 50). To be sure, “the history of every country begins in the heart of a man or a woman” (p. 64). Like the pioneers who left the security of what was familiar in the Old World to explore the unknown New World, the possibility of finding a nursing role that better fulfills one's needs and desires in the future acts as the beacon for knowing when the right course has been charted, even though how, when, or what shape the course will take is not known at the outset. Understanding this fosters sensitivity to the tensions and struggles ACNPs experience and how they choose to live being an ACNP. It is in understanding what the “perfect fit” can look like for each ACNP that there can be an appreciation for why some ACNPs are more content living the role totally occupied by the direct clinical practice component of their role, while others seek engagement in the multiple components of this advanced nursing practice role. Finding the “perfect fit” is about the search for the possibilities of being and having “more” in their lived experience of being nurses.

The Call

> Alice was beginning to get very tired of sitting by her sister on the bank, and of having nothing to do: once or twice she had peeped into the book her sister was reading, but it had no pictures or conversations in it, ‘and what use of a book,’ thought Alice, ‘without pictures or conversations?’ So she was considering... whether the pleasure of making a daisy-chain would be worth the trouble of getting up and picking the daisies, when suddenly a White Rabbit with pink eyes ran close by her..... [And] when the Rabbit actually took a watch out of its waistcoat-pocket, and looked at it, and then hurried on, Alice started to her feet, for it

> flashed across her mind that she had never before seen a rabbit with either a waistcoat-pocket, or a watch to take out of it, and, burning with curiosity, she ran across the field after it, and was just in time to see it pop down a large rabbit-hole under the hedge. In another moment down went Alice after it, never once considering how in the world she was to get out again. ~ Louis Carroll, 1865/1971, p. 1-2

Certainly the call to be an ACNP is not always heard clearly or understood at first and the destination for many is unclear. Lewis Carroll (1865/1971) depicted variations on this theme in one of the most famous of all journeys in children's classical literature, *Alice's Adventures in Wonderland and Through the Looking-Glass*. Like Alice, some nurses leap "down the rabbit-hole" without a moment's hesitation, while others lag behind, watching the experience of others and then following their lead. For some, the desire to be an ACNP is driven by a vague pull toward something more. Not quite satisfied with who they are as nurses in what they are currently doing, they are willing to test new waters and sail to destinations unknown, unsure of what it is they are looking for, but hoping that it will be revealed along the way. Nevertheless, knowing what they value and what they no longer want becomes their North Star on the journey.

For others, setting out on the journey to become an ACNP begins with a dream, and like every great dream, the dream is built around a picture or vision. They are motivated to pioneer the role and continue to be fortified during the journey by their ability to reflect upon what this new role can mean to the patients or to nursing. Their reflections about the possibilities of this new role brings them to a new consciousness of nursing; they are almost able to feel a new relation to it through their envisioning. The following description of how one nurse created her own ACNP position illustrates this vision for a better fit for both herself and her patients and is an example of what it can mean to be a pioneer.

Joan worked in a program whose patient population had outgrown the number of personnel that could provide the complex clinical service needed in an effective manner. At about the same time, the provincial government was looking to fund programs that were delivering care in innovative ways. In her role as a CNS, she used this external call as the mechanism to submit a proposal for a five-person interdisciplinary team with a NP role (a role she envisioned for herself) that would deliver "one stop care" to the patients in the program. A physician, nurse practitioner, social worker, pharmacist, and clinic nurse received funding to deliver the holistic needs of the entire specific patient population for the province, a population of approximately 900.

> I was offered a position as a clinical nurse specialist in the [program]. My role was to be a specialist in that area, knowledge wise as far as nursing. And over the years I developed a

> number of skills. ... And what I found out, what I wanted to do, was basically to broaden my practice. And so I actually discussed changing my role with my medical director because I needed to know that he would support it once I had completed it, and I also talked to other nurses that were working in similar roles already, and also some of the other clinical nurse specialists who I'd been working with for a number of years. And really what I wanted to do was to be able to marry the kind of things that are called physician practice, things the physicians are felt to be responsible for, but I wanted to bring in my nursing. I also wanted my nursing skills and my nursing perspective to be incorporated into my practice at the same time. So I looked at the program that was being offered here and it looked like it would give me the kind of background that I needed to perform the role. And I did get the support of a number of people to say that if you complete this role then yeah there is a position here for you and there's something that we would want you to do. I was basically creating something new. ... And what I wanted to do was really focus in on a certain group of individuals who I felt were falling through the cracks in our health care system.

For nurses like Joan, the dream of being an ACNP is fairly detailed; they are dream weavers, setting out to find or create a nursing role that is the perfect fit for them. Their dreams are like the coats created by the Navajo Indians, whose designs are woven with such vision and skill. When a weaver begins her work, she creates a design in her mind, but often does not commit herself to a final pattern. As she works, she steps back from her loom frequently to see how it is progressing. If the design is not coming out the way she envisions, she pulls out the yarn and begins again. If the pattern is too busy, she simplifies it. If the design needs depth, she adds a new color or texture. Always, she keeps in mind the feeling she wants to convey in the final product. As weavers of their roles, some nurses create a mental picture of their destiny as ACNPs – a vision of who they want to be and what they want to accomplish. It is up to them to select the patterns, colors, and textures of their lives in this role. It is up to them to frequently step back from their lives in this role, to judge how pleased they are, and decide what changes they need to make. It is up to them to take great care with the ACNP role they are weaving and create a design of beauty and balance, a coat that is the perfect fit for them. Being a pioneer makes the emergence of this creation possible and the vision becomes the sextant used to navigate their journey.

This is not to say that the nurses' dreams or desires include the map for how to get there or even what the exact destination will look like. Yet, whether visionaries or seekers, as they struggle to find a place within their clinical program, organization, and profession as ACNPs, they find that their desire for "more" is what is needed to help them deal with the tensions and turbulence they experience throughout their journey. The constant refocusing and reflecting on what called them to the ACNP role in the first place helps them to visualize the difference they wish to make, the people they want to help, and the goals they hope to achieve. Then they can see themselves becoming that which they dream or desire. Ultimately, their desire for more helps them determine when they have found the "perfect fit," helping them to know when they have reached their personal destination of being an ACNP.

William Bridges (2003) wrote that identifying an ending is needed to reach a new beginning. The following lines in T. S. Eliot's (1959) poem "Little Gidding" capture this same intent.

> What we call the beginning is often the end
> And to make an end is to make a beginning. (p. 58)

But what are the endings and the beginnings of the ACNPs' transformational journey?

> I love nursing and I always wanted to be a nurse and I always felt like my heart was in nursing. As I went from area to area and moved and did my bachelors and did my master's, a lot of my friends said 'why don't you go into medicine?' And it just was something that, it kind of, every once in awhile, played a game with my head, and I thought well maybe I should go into medicine. But then I thought no; I'm a nurse; and I want to be a nurse; and my view of the care of the patient is more in line with what I felt nursing is, which to me is more of a holistic view of the patient. And so I thought that perhaps there was a different way to nurse that would more satisfy what I wanted to do, so I had some more independence but could practice clinically. I love clinical work and I love acute care. So somehow the idea of the ACNP role gave me more of that independence, and then acute clinical care, with more responsibility that I was able to do, but yet not be a physician.

In choosing to seize the opportunity to become an ACNP, nurses perceive possibilities for "being" in this role that they cannot perceive themselves to be in any other role. Even though many ACNPs continue to journey through or live with a variety of tensions as an ACNP, part of their struggle stems from living ways of being in the ACNP role that they do not want to relinquish. They have found a partial fit with what it is they want to be in their nursing lives and remain hopeful that this role will still offer the fit for which they are looking. Being in direct patient care practice is an integral part of that fit, for at the heart of nursing is "the opportunity to work with patients, hands on, all the time." For those nurses already in patient care roles (e.g., bedside or transport nurses), the ACNP role offers the possibility of "being more" in clinical practice without requiring they leave the profession. For those nurses who have been away from "hands on" care, the role offers the possibility of returning to the type of nursing role they love, combined with the opportunity to live out "the more" they have found in other nursing positions (e.g., administrative leadership or education).

What draws nurses to the ACNP role, a role embedded in patient care activities? For some, the ACNP position offers the opportunity for more diversity while still retaining a strong clinical focus, while for those who are still drawn to the excitement and "the heart, or the heat of everything going on with the clinical situation," the ACNP role offers more opportunities for this adrenalin rush. As one participant stated as she reflected upon why she had left her program management role for the ACNP position, "I was missing the excitement and the fun of the new things happening in acute care." The opportunity to be "doing stuff" for their patients, while staying connected with them over a longer period of time and across different places is also very appealing. Definitively, the vision or desire for "more" is inherent in all the reasons for initiating the journey to becoming ACNPs.

One particular story offered by a neonatal nurse practitioner beautifully illustrates this desire for more. She had worked in a variety of nursing settings over the course of her twenty-five year nursing career – antepartum, labor and delivery, public health, toddler surgery – all intertwined with various stretches back at school. Always, she had come back to the neonatal area. She had pioneered the neonatal transport program and as she expressed, she loved the autonomy that it provided. The "big attraction was the mindset" needed on transport, "being able to put the pieces of the puzzle together and do the critical thinking." As she said, "it's about the diagnosing and coming up with the solution and being able to work collaboratively and build partnerships with our medical colleagues" that she loved. But, as she identified, "I wasn't happy enough. I wanted more when I started doing it." The transport role had wet her appetite as to the possibilities of what more she could be and do as a nurse, what more she was capable of, and what more she could offer to the patients. Perhaps, it is as Antoine de Saint-Exupéry (1943) revealed to us in *The Little Prince* - the beauty of the desert is the well hidden somewhere within (p. 75). She discovered possibilities for being as a nurse within herself that she liked and desired and chose to bring them into the light. When the prospect arose for her to pioneer the ACNP role, she felt that it provided the opportunity for her to "learn more, to maximize [her] potential" and to "contribute and make a difference" "in a broader way" to the patients and their families, as well as to the nurses at the bedside. At the same time, it would complement who she already was as a nurse. For her, the ACNP role "made perfect sense."

Many of these reasons so passionately expressed by this participant were also discussed by the other ACNPs. Each of their stories demonstrates the interconnected nature of the multiple and complex factors that call them toward the possibility of attaining more within this "hands-on," direct clinical practice nursing role.

Being More Connected

Being connected, physically and emotionally, to patients and families is an incredible pull for becoming an ACNP. One participant had worked in a cardiology clinic where she enjoyed being recognized as an arrhythmia expert. She also cherished the freedom bestowed upon her by the physicians to detect/diagnose pacemaker dysrhythmias, as well as to re-program the pacemakers as necessary to fix the problem. However, she felt that she had become very technical in her nursing role. She "felt a loss of nursing" and so returned to an inpatient bedside nursing role where she could feel more of a connectedness to the patients and their families. Yet, in this role she felt the loss of self-sufficiency and recognition she had formerly experienced. Consequently she was "looking for something more" when the nurse practitioner program at the local university opened its doors. She knew immediately "it was what [she] wanted to do." Likewise, others described being in clinical management or clinical educator positions as being "too far away from the patient." As one nurse said, the ACNP role opens the possibility of "being able to combine teaching with team leadership and a bit of research, while allowing me to stay close to the patient. This is a good fit for me. It gives me all of the things that I think are important about nursing."

Establishing meaningful connections with patients and their families and being involved in a personal way is at the heart of caring and commitment in nursing (Benner & Wrubel, 1989; Parse, 1981; Perry, 1998; Watson, 1988). As noted by Bishop and Scudder (1990), even if individuals have not been initially attracted to nursing for this reason, this sense of connectedness becomes embedded in their personal sense of nursing if they make the choice to remain in the profession. One participant shared how restless she had become in her work as a clinical educator in large part due to her feelings of disconnectedness from the patients and families. "It's all about the patient...whether you're in administration, education or research…but I was afraid that I had begun to move too far away…and I never wanted that [being disconnected] to happen." She shared that one of the driving forces behind her decision to pioneer the ACNP role had been the opportunity to be more personally connected with patient and families, while still being able to connect with and make a difference to her immediate nursing colleagues in the education component of the role. In addition, she could make larger system changes within nursing, something she had experienced as an infection control nurse. As she continued in her reflections, she revealed the circular nature of her entire nursing journey. "It's fascinating to go back and look at where your career path has taken you and the steps that you took that you weren't sure where they were going to lead, but in fact, in hindsight, do lead up to you integrating those skills." Having worked as a candy striper during her adolescence, she had been drawn to the scientific focus of medicine. But even at that time, she knew she would not like "the episodic" aspect of their care. As she said, "I didn't want to be in a position of just popping in and popping out. I wanted to actually understand and develop relationships with people over a longer period of time." So it "struck" her that nursing provided her with the "opportunity to be with patients and families over a long period of time and still have the scientific component." However, the traditional bedside nursing rôle had eventually not been challenging or autonomous enough, hence the sojourns to other nursing roles that took her away from "hands on" clinical practice, the only alternatives at the time. The creation of the ACNP role finally offered her the possibility of being "stretched" more intellectually in the multiple dimensions of nursing, while at the same time, being more intimately connected with the patients and families over long periods of time. As she summarized about her path to becoming an ACNP, timing, recognition, being given a "free hand" to essentially "do your own thing," were the type of career roles in nursing she found "really neat," "really cool," "really fun," and the "perfect fit" for her. As she said, "How often in your career do you feel like you've really made a big difference, that the work you've done has changed the people you work with and the patients that you take care of?" The ACNP role "gives me that little bit extra that I wanted." It is "the ideal role."

Being More in Control

> Is it the autonomy that's attractive? Is it the ability to be able to find the solution to the puzzle, if that's what you could call a diagnosis, or the ability to be able to act maybe a little quicker with writing the order and ... if you see something and you know what it is and then having that autonomy with being able to write the order? And also with the added skills to provide the intervention and then reevaluate it again?

Some nurses are strongly attracted to the lure of finally being able to have both increased responsibilities and the autonomy to act in their clinical practice. In other words, many nurses seek to have control over their practice, something they feel has been missing or has eluded them in their role as bedside nurses. As one participant so vehemently expressed upon revealing that she had been "searching for something and thinking the nurse practitioner was what [she] wanted to do":

> It was a little bit of independence, autonomy, which I think I was probably the most important thing. And challenge. But mostly it's the autonomy issue. I've always felt a little bit constricted by the fact that you have to wait for a doctor's order for Tylenol and you have to wait for a doctor's order for this and that, even though you know what's required. I felt very

> constricted by that you know, calling the physician, suggesting what needs to be done even though you know what needs to be done, and waiting for their order to do it. So, that was something that was right when I first started nursing. As soon as I started getting some skill in nursing I started realizing that as a nurse I felt a little bit constricted under the current system and I was looking for a way to gain more autonomy.

Suzanne Gordon's (2005) journalistic work passionately speaks to the health care systems that severely restrict what nurses can do without a doctor's order, which both creates problems and reinforces status and power hierarchies between nurses and physicians, a deadly Catch-22 situation. Quoting Gordon Schiff, an internist at Cook County Hospital, Gordon reported this same scenario from the physician's perspective.

> Every night, a thousand times a night, all over the country, nurses are calling doctors reporting that a patient has a fever and asking doctors what they should do about it, or asking the doctor whether they should give the patient Tylenol. And every night, doctors are berating nurses for calling them up and bothering them, because they are reporting a fever, and the doctors are thinking to themselves, 'Why are you so stupid that you are asking me whether you should give Tylenol?'" (p. 48)

As these quotes demonstrate, this situation is prevalent within nursing. Nurses are restricted in what they can do for patients without a physician's order.

For many in nursing, being a nurse practitioner then is a "stepping stone" to becoming more knowledgeable and more autonomous. Indeed, for many nurses, the frustrations with practice limitations and the inability to experience their own potential in the traditional bedside nursing role leads them to consider either applying to medical school or leaving the health care field altogether. However, the introduction of the ACNP role now offers nurses the opportunity to remain rooted in the nursing profession in direct clinical practice. Paradoxically, it also enables them to set sail for a new, albeit unknown, destination that holds the promise that they can have more independence, more autonomy, and more responsibilities, particularly related to the health care management of the patient. The role holds the possibility of giving nurses more control over the decisions about patient care, both in terms of the treatment plan, as well as the way in which the care can be delivered. There appears to be a promise that in this role nurses will be able to take more initiative in their clinical practice. More knowledge and skill combined with the authority to use more of their abilities in a "more well-rounded" way potentially enables them to make more of a difference. This finding was similarly expressed by a group of American primary care NP pioneers during the mid 1960s and throughout the 1970s (Brown & Draye, 2003).

> At the time I was in a staff role and I wanted to do something different. To be honest, I was frustrated with nursing. I seriously considered going to medical school because I felt I was at a bit of a cross roads because I was frustrated by a lot of the practice limitations in

> nursing. ... The focus on what's best for the patient was lost under the power struggle of whose role it is to do. The focus wasn't on delivering the best patient care, it was on who has the appropriate title to do x amount of care. I mean just one example, a patient has a headache. As a nurse you've certainly got the knowledge and expertise to know they need Tylenol but you can't give them Tylenol until you call the physician to get an order for plain Tylenol. You know I found that kind of thing incredibly frustrating because it wasn't a matter of the nurse not having the knowledge and expertise; it was the role limitations, the barriers to optimal practice. So the patient's suffering while you're jumping through these hoops to get something that the nurse should be able to deliver. ... So I thought to myself, I either jump ship or go into medicine, which didn't really appeal to me because I love nursing. I really enjoy being a nurse and that's where my heart is. And I knew by that time what I'd be giving up to go into medicine. So it was a matter of I'd be giving up all these things but I'd be gaining these things. And I finally decided that that wasn't for me; I didn't want to do that; I wanted to stay in nursing. I was going to stick it out but I would do my masters preparation which would give me the background to have more options. And at that time the NP role had been piloted at [hospital]... they were trying new territory and they had to explore that and see how that was going to work. And I decided that it might just fit for me.

The desire for more freedom to explore and achieve one's potential by being given permission and the authority to do more in the practice setting becomes a strong motivator for enduring the challenges of becoming and being an ACNP. Nurses are drawn to the notion that the focus of their practice can be "on how to deliver the best care to the patient, not on who has the right title." They are attracted to the promise that they can not only acquire increased knowledge and skill related to decision-making, but also to the possibility that they will be permitted to apply that knowledge and skill in their practice. Akin to wanting more control is the desire for more flexibility in their nursing practice. Wanting to be more involved in all aspects of the patient's care, "the social, the emotion coping, the stressors piece," including the medical care and liking the "flexibility in meeting the patients' needs along with the responsibility and accountability," results in an attraction to a role where nurses feel they will be able to "direct the care in collaboration with physicians." Moreover, they are drawn to the possibility of making their own time to spend "that kind of time" with patients and families.

Being More Visible

> It was about the diagnosing and coming up with the solution and being able to really work collaboratively and build those partnerships with our medical colleagues. ... And so what could I do as a nurse? How could I take that into the patients in the unit and work with a team ... and how could I contribute and make a difference? And I felt as a nurse that one of the opportunities to present itself would be to become a neonatal nurse practitioner. .. Well I guess, it's like that power, not power, but the sense of fulfillness that you have at the bedside when you work together ...being part of the team in terms of how could I, as a nurse practitioner, be more part of ...working collaboratively with making that plan..., but working with the nurse, working with the *whole* [emphasized] team of how we can make a difference, but really being part of that discussion.

Becoming an ACNP is not just about the opportunity to be more in control. It is also about the call to be more visible. The search for more of a collaborative practice, to have more of a feeling of being a member of the team, to experience a feeling of "really" being valued, inherently speaks to the search for becoming more visible. There is a desire to have one's voice heard and to be recognized and acknowledged for one's own agency. Nurses become tired and frustrated with being viewed as "just a nurse" (implying to be merely engaged in insignificant work) or "just temporarily borrowing the doctor's agency" (Gordon, 2005, p. 50). The ACNP role is seen as an opportunity to be affirmed and recognized for what they really know and do, rather than having their actions attributed to the physician. For instance, some nurses are tired of the evasive and roundabout language that is required in order to show deference to physicians. They no longer want to play the doctor-nurse game of arriving at the identification of the problem and/or plan of care without venturing on the medical territory of diagnosis and treatment or prescribing. This is demonstrated in the following excerpt of the frustration one ACNP experienced during her role as a critical care transport nurse. Rather than writing or reporting that the infant had a suspected pneumothorax, the nurse could only describe the signs and symptoms without actually using the sacrosanct medical term.

> And still, even now, nursing is never allowed to call it what it is, diagnosis. You know, when I'm out on transport we are describing medical pathophysiology diagnoses to families and we can't call it that, because that's beyond the scope of nursing. And yet with our added skills we do know what it is that we are talking about in terms of the diagnosis. And it's just fascinating! I mean I guess the one that comes to mind so much is the pneumothorax. So you have an air leak happening and the baby's telling you what symptoms he's having; you're looking at an x-ray that's telling you my baby has a pneumothorax. And the parents are asking me: "Well why are you putting that needle in the chest?" And so, you're going: "Well he has *symptoms* that are *suggestive* of a hole in his lung, an air leak. No. He's got a pneumothorax. It's a diagnosis. Like it just, it just boggles my mind to try and get the wordsmithing around just to stay within the scope of nursing.

Nurses are forced to engage in a game of words, describing aspects of what they see, presenting the answer in the form of a question, but never forming a conclusion. "Maybe it could possibly be this, or maybe you should consider this?" When they arrive at a plan of care, that plan can never be called a "treatment." They can only make suggestions to the physician and if he or she agrees, the nurse has not been seen to have "prescribed." "Would you like to order 40 milligrams of Lasix before I give this unit of blood because the patient's pulmonary pressures increased the last time?" Even in those settings where nurses can change ventilator settings, wean inotropic agents, insert catheters, and initiate intravenous fluids, after which they get the physician (resident) to write an order, the treatment interventions are presented on rounds in such a way that it is viewed that the nurse acted on the physician's behalf. It is not uncommon to hear staff physicians inform new residents that nurses know their preferences. All this reinforces what physicians admit that they have been taught through informal or formal lessons and socialization; that is, "the nurse is stupid, because she uses dumb language, makes dumb suggestions, and doesn't know anywhere near what the physician knows" (Gordon, p.49). Nurses "have no real agency of their own" (p. 50). As one ACNP noted:

> I think as nurses, and coming from a lengthy nursing background before nurse practitioner, the physicians almost have a attitude of [using tone of dismay] you're just a nurse, like just tell them what to do and they'll do it, and they don't need to know. And he's made that comment about nurses. … I mean I always think back to when I worked in ICU and as a bedside nurse what they would do is the doctor and the residents and respiratory therapist would go from bed to bed and the nurse would give report. And so many times I witnessed they're all like this [turned away – bored look] until the nurse is done talking and then the resident would essentially say the exact same thing as the nurse did. And it was like brand new news to them because it wasn't the nurse talking any longer. So I felt that way a lot as a bedside nurse in that it didn't matter really what you said it was what the resident came up with in the morning that, whether it was true or not, that's what the care plan was going to be for the day.

These various doctor-nurse games (Stein, 1967; Stein, Watts, & Howell, 1990) conceal nurses' mastery of their knowledge and skills and its importance to patients. Nurses remain barely visible to physicians, except as objects of derision and disrespect. As one participant shared, nurses are visible to society as individuals who "carry a bedpan for a living, being a bedside nurse when you start, a bedside nurse when you retire, and a bedside nurse when you die." They are viewed as individuals "who operate on a field that has already been prepared for them by the doctor" (Gordon, p. 148). These statements illustrate that our society has remained socialized to see nurses and nursing as stagnant, lacking in ambition, curiosity, and intelligence. Would those individuals within nursing not have attended medical school otherwise?

Becoming an ACNP then speaks to an opportunity to be visible and credited with having knowledge and skill, for being affirmed as bright and capable, with being acknowledged as making a contribution to patient care, all without having to become a physician. The ACNP role carries with it the opportunity for more recognition and acknowledgment for the differences they made in the lives of their patients and families, by society as a whole, and the physicians with whom they have worked side by side for many years. Many nurses want to experience a greater sense of worth as nurses, a feeling they have achieved in only limited ways as a bedside nurse.

In Hegel's (1807/1971) story of the master and the slave, as presented in *Phenomenology of Mind*, two individuals approach each other from opposite directions along a path. As they approach each other, they desire recognition – for they do not really know who they are until they see themselves in another's eyes, until they are recognized by an "Other." Such a recognition is the recognition of one subject by another as equal human beings, ultimately very much the same. Yet they fear the Other will deny them this recognition, will force them to submit to their will and move off the path. So they fight until one submits. At this exact moment, Hegel sets the clock of history ticking, "for history is no more than the lone struggle of the slave to be free and to gain recognition as an equal" (Carlson, 2002, p. 10). Our very sense of who we are – our identity – is constructed in relation to the Other and has no autonomous meaning. For Hegel, consciousness is always limited by its embeddedness in history, and thus neither the master nor the slave is able to think outside of the modes of consciousness that are available in the culture at a particular point in time. He would argue that if nurses are never able to rise outside of history and positionality, then they will remain invested in their historic role. Is it possible that nurses who desire to be ACNPs recognize this pioneering journey as an opportunity to be active agents of culture and history, shaping what nursing can be and in the process act in ways that lead to recognition, as well as more control, previously denied nurses and nursing?

Being More Challenged

> A lot of the excitement is in the diagnosis, in the seeking of information, putting the clues together and being given permission in this role to be able to read the chart, ask the questions, and maybe part of it is the inquisitiveness or the intuition that takes you to the next step - Have you thought of? Did you? Would this have made a difference? Why are we doing things the way we're doing them? Have you? So maybe the nurse at the bedside doesn't feel as empowered with that? Or comfortable with it? Maybe it's a level of competence and I felt I was fairly competent at the bedside and ready for another learning opportunity and role expansion.

Thomas Henry Huxley[11] wrote that "the rung of a ladder was never meant to rest upon, but only to hold a man's foot long enough to enable him to put the other somewhat higher." When some nurses feel a sense of ease with the nursing terrain that has been already explored, they are challenged to extend the horizons of their actions and to risk their stable identity for the sake of another precarious identification with their world. They seek to feel more challenged in their practice, to feel more stimulated in their work, to feel that they can continually grow and learn as nurses. Although this can be accomplished through a transfer to another type of specialty nursing, advancing one's education or moving into education, administration or research, none of these options are perceived as the "perfect fit" for those nurses seeking a multiplicity of "mores" at the bedside.

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[11] Cited in *Bartlett's Familiar Quotations* (1992) from Leonard Huxley, Life and Letters of Thomas Henry Huxley [1900], vol. 1.

The desire to be "stretched" or to "expand one's wings", the desire for personal growth woven into a need to be challenged and to "feed [one's] inquisitive nature" is a common thread to who ACNPs are as nurses. Indeed, many participants expressed their good fortune and gratitude at having had mentors along the way who had seen their potential and then encouraged and provided them with opportunities to push and test the limits of their abilities. They spoke to their desire to "maximize" their potential, although many were uncertain of what they were capable when they initiated the journey to becoming an ACNP. There was a restlessness, a yearning, or a searching for something more than who they were in the role(s) that they had inhabited, although they did not wish to lose that which they found satisfying. But they all expressed a desire for more knowledge and skill, which they could then bring to their patients and families. The ACNP role was perceived as opening up the opportunity to be able to "continually move." It is "the perfect fit for someone who loves to study and wants to constantly strive for more knowledge and skills that can be used at the bedside, close to the patients and their families." The role was seen as providing more educational opportunities, both academic and clinical, which has the potential for challenging one's intellectual abilities and for revealing the multiple possibilities for one's being as a nurse in clinical practice.

For some ACNPs, there is a strong attraction to the scientific focus of medicine. It is expressed as a desire for more "anatomy and physiology" in particular, or "the study of math, biology, chemistry and physics", something they had wanted even prior to entering nursing. There is a shyness or reticence to this frank admission of something which is now deemed to be politically incorrect in the realm of nursing, an outcome, intended or not, of the discourse of authors such as Mitchell and Santopinto (1998), Rogers (1972), and Sandelowski (2000). However, they had chosen less depth of knowledge in this area in order to achieve "the broader perspective of human life and the human condition" that nursing offered. A desire to learn more technical skills, to be mentally stimulated by the complex problem-solving inherent in making a diagnosis, and to feel that "you're doing something that's making a difference to someone's care" in terms of their biological status, really "turned [some of them] on." However, this acknowledgment of being drawn to this type of knowledge and skill was always embedded in the recognition that this is not nearly enough for them in their practice. As noted earlier, ACNPs do not want to be in "a position of just popping in and popping out" of their patients' and families' lives. They are searching for deeper relationships with their patients over a longer period of time. Becoming an ACNP gives them that "little bit extra" that they want in terms of more knowledge and skill, embedded within a connected relationship to their patients and families. As one participant summed up, "it really is an ideal role" that offers the opportunity to attain more depth in the "medical sciences" which, when combined with nursing knowledge, better enables nurses to meet the patients' needs in a more timely and holistic manner.

For some nurses, although certainly not all, there is the enticement of the opportunity to integrate many different aspects of practice. This appears to be particularly true for those ACNPs who have held a diversity of nursing roles throughout their careers, such as being a CNS, a clinical educator, an infection control nurse, or a clinical manager. This is articulated particularly well in the following excerpt from an ACNP who explained why she had been drawn to the NP role.

> But being able to bring all of the experiences that I've had throughout my career, being able to work with a variety of people, being able to make a difference at the bedside, but also being able to do some of those other more advanced practice roles, being able to go to conferences, present, publish, do research, mentor colleagues, being able to interact with different people, different organizations, I think all of those things were really critical for me.

Some nurses want to feel "more well-rounded", so the opportunity for more diversity that they perceive to be embedded in the ACNP role is also very alluring.

> It's sort of the best of both worlds, because ... you get to provide clinical type care, which is one aspect, but also to be able to have the contact with families, the education piece with staff, with families, with residents. I just found it a well-rounded position. But you're not a physician; you don't want to be a physician; but you have the ability to do more than just a bedside nurse. ... I really saw the role as encompassing family centered care, education, the opportunity to do some research, and a little bit of administration if you chose to do that. So really an advancement in nursing but staying as a nurse, because I was always proud, I always wanted to be a nurse ever since I can remember. I'm just one of those people who like to be challenged.

In addition, for some nurses, there is the call toward leaving that which is familiar in order to explore uncharted territory; that is, the challenge of being a pioneer is in and of itself an exciting opportunity to test one's abilities, creativity, and initiative. Frustrated by the circumstances of traditional nursing jobs and "itchy" to develop and use their full expertise and potential, these nurses exemplify what it means to risk what is known in order to open up to the landscape of possibility for the sake of securing a greater hold on their world within nursing.

> And I really felt it was important to move along and see myself as taking on a challenge that not many people have taken. So I felt I was one of the first people that saw the nurse

> practitioner as a way to expand my wings and went for it and got in and it was just really exciting to be moving in a new direction.

Nurses are socialized to be nice, to be docile. Perhaps nursings' socialization can be viewed as 'shrink to fit': shrink oneself to fit what others expect of you. As Brown and Draye (2003) expressed on behalf of their participants, and which is confirmed in the stories of these ACNPs, NPs are emphasizing that their struggle is not for autonomy for its own sake, but as a means to transcend the limitations in the traditional beside nursing role. They are in search of a new fit that stretches their own personal abilities and provides the opportunities to discover their own possibilities for being.

Being Able to Make More of a Difference

A desire to deepen, broaden, and strengthen one's knowledge, skills, and abilities regarding the medical aspects of the patients' care, matched with authorized application (associated with *being more in control*), is intimately embedded with a desire to provide more effective and holistic nursing care. The ACNP role, perceived as offering the opportunity to know the patient's clinical condition in more depth, speaks to a desire to better understand the patients' underlying disease processes and to have a greater repertoire of interventional tools and skills in order to better help the patient and family. It is envisioned that the additional knowledge and skill will enable them to provide even more holistic care and thus make more of a difference.

Waiting is part of the lived experience of being a nurse. Nurses live with the necessity of having to wait for physicians to see the patient. They wait for the physician to be of the same mind regarding the needs of the patient as brought forward by the nurse on behalf of the patient and/or family. Rather than wait, becoming an ACNP in order to be able to make more of a difference includes the vision of being able to provide more timely care.

> Nothing bothers me more than to see a patient writhing in pain while the nurse is struggling to get hold of a physician who won't answer his page or having to wait until the physician gets out of the OR, or whatever they're tied up doing, before the patient gets an analgesic.

Intimately privy to the increasing fragmentation of care in our modern health care system, there is also the vision of being able to provide consistency and continuity of care over time, rather than the "snapshot" and "episodic" or "sporadic" contacts that tend to occur within the medical model of care in the hospital setting. This too would better facilitate meeting the holistic and multiple health care needs of the patients and their families.

> Well, the big thing, the driving force for me was that there was this role that was written in the literature that neonatal nurse practitioners can do so much more for your families and patients. And at that time, we were talking about bringing in a care provider, a physician, who could be some doc from a doctor's office, or a replacement who'd come through the city who didn't know our babies well, maybe didn't have a whole understanding of neonatology, and definitely not the dynamics of neonatal programs and family centered care and developmental care, just the general pathologies that we see in the neonatal population. [Yet] we have nurses working at the bedside who are experts, who do have an understanding of those, working with our families day to day with certain groups of babies. And yet we were having strangers come in and look after them and write the orders. And here was an opportunity for nurses - and the literature supported that nurses could be given the education and be able to be that care taker – to advocate for - and knows our babies and provide the continuity of care, the consistency of the relationship with the families. And the literature supports that with the right education that an expert neonatal nurse can make that transition to being that practitioner more than adequately.

The ACNP role is also perceived as offering the opportunity to make change for patients and families, not only in relation to the patients' biological needs, but also in terms of the variety of other needs that present as a result of the physical illness, "those quality of life issues that the doctors just don't have time for or care about really." The ACNP role is seen as an opportunity to utilize one's creativity and initiative in new and expanded ways to bring about system-wide change processes that can result in making more of a difference to patients and their families. Some nurses, particularly those who have been in CNS positions, are also drawn to the possibility of making a difference to the nurses with whom they work and the nursing profession as a whole, while retaining a focus of clinical practice at the same time. There is a strong desire to make a difference to the staff nurses by "marrying" teaching, research, and leadership with advanced nursing care at the bedside. As one ACNP who had already been in a classroom and a manager on an inpatient ward explained, what drew her to the ACNP role was a desire to combine all of what she enjoyed within those roles with a focus on the clinical aspects of patient care. The ACNP role is perceived as an opportunity to build the health care team in a new and different way, and in such a manner that nurses can see a difference in their practice for both the patients and themselves. As another participant reflected, she feels the ACNP role offers more of an opportunity to demonstrate to junior nurses a whole spectrum of options in the clinical setting, "as it is not many people who stay in one area for twenty-five years." She hopes that by being a role model for her nursing colleagues, she will be able to heighten other's awareness of what nursing brings to the patients and families, and hopefully retain and thus attract more nurses within nursing, particularly in the clinical setting.

Answering the Call: Initiating the Journey

It is not always easy to hear the voice from the centre, let alone heed it. But once it is noticed, some form of action is required. It is here that some may decline to journey further. Even when they experience a fresh awareness into their discontent, they swat it away like an annoying fly. Others disperse this uncomfortable energy by talking about it incessantly, so they never gather and hold the energy to do anything about it. But some, like Alice in *Alice's Adventures in Wonderland* (Carroll, 1865/1971), Santiago in *The Alchemist* (Coelho, 1988/1993), or Bilbo Baggins in *The Hobbit* (Tolkien, 1937/1966), say yes to the call. They seize or create opportunities to initiate their quest in search of more, even though it is at this point that saying yes to the journey means facing the first demon – fear of commitment to a journey of unknown consequences. Commitment, in fact, can be quite sobering. In answering the call to leave the cave, we must step into the chilly, uncertain waters of the unknown and enter into the area of risk. Perhaps this is more aptly expressed by Morpheus to Neo in the film *The Matrix* (Silver et al., 1999). Just at the point that Neo must choose between staying safely in his "cave" or beginning his search for the truth about the Matrix, Morpheus utters: "I imagine you're feeling a bit like Alice, tumbling down the rabbit hole." Yet saying yes to the journey is an invocation that can connect us to all those who believe in the power of the journey, and, as noted earlier, once we are ready to commit, opportunities and circumstances seem to open in a most serendipitous unfolding.

W. P. Kinsella (1982) wrote in *Shoeless Joe*, a work of fiction immortalized in the movie (Frankish et al., 1989), *A Field of Dreams*, "if you build it, he will come." We are told in this story that all his life, Iowa farmer Ray Kinsella has been searching for his dreams. Then one day, his dreams come looking for him when a voice in his corn field says these words to him. He seizes this message as an opportunity to pursue his dream. Initially he builds a baseball field on his farm, upon which the ghosts of Shoeless Joe Jackson and the other seven Chicago White Sox players banned from the game for throwing the 1919 World Series. But when the voice continues, Ray seeks out a reclusive author to help him understand the meaning of the message and the purpose of his field. Both American and Canadian nursing history has shown that a seized opportunity for nurses to follow their dreams has often come as a result of questions and concerns about the lack of resident coverage in the tertiary care institutions. Pioneer ACNPs have been made privy to the debate about who best to fill the service gap through discussions with their immediate supervisors, many of whom are recognized and acknowledged as Athena in the guise of visionaries. For some nurses, the desire for change and personal growth, particularly in the direct clinical practice arena, has been present for many years. However, without the creation of the ACNP role by nursing visionaries, many may have remained as bedside nurses, turned to management or teaching, or left nursing altogether.

> They did an assessment of how they were going to replace residents - because there's been a reduction in residents - and the nursing department took this on. And they felt what they needed to do was to look at the gaps, the clinical gaps in the hospital around the resident, but also around nursing. On the surgical floors one of the gaps they felt that there was, was accessibility to surgeons during the day because they were in the OR, or in clinics, and they couldn't reach them, and so there were communication gaps, and there's some specific surgeons that there were issues with communication with nursing and allied health. So they developed what they called the expanded role nurse position which they felt would best suit filling in the gaps of reduced residents, but also filling in the clinical gaps within the hospital for nursing. They felt there needed to be more nurse education, there needed to be more mentoring and nurse experts in the building, so the role came about with looking at all those gaps. And they came up with expanded role nurse and I was one of the first ones. We called it expanded role nurse at that time but we were doing physical exams and medical histories. We were trained for that and we also had to get our master's in nursing at that time too as all part of it. ... I was in the right place at the time. I was one of the few nurses on the floor who had a bachelor's degree and I was ready for a change.

It is equally important that there be visionary physicians who embrace the ACNP role. Pioneer ACNPs are cognizant of "the tremendous good fortune" to work with a "wonderful group of physician colleagues" who are "not threatened with the idea of sharing their practice knowledge with a new role, a new person," and who hold a view that this role can be "a collaboration," not a replacement for residents. In short, opportunities are built and some nurses come forward to seize them. Nurses view this occasion as an opportunity to join the movement to advance the profession of nursing as well as to search for the "perfect fit" and make the choice to be pioneers of this new role. Many of those who have shared this type of story have come from the neonatal intensive care programs. They are nurses who have already experienced the pioneering process associated with the establishment of the nurse-driven neonatal transport teams. "Appetites wetted" by the opportunity to expand their critical thinking skills, decision-making abilities, technical skills, and autonomy, the in-house setting is seen as a natural expansion of their nursing practice, a form of "realignment in trying to blend nursing with a little bit of medicine as well as [their] role in the transport setting."

Some CNSs choose to become ACNPs because they either hear the unsettling rumblings of distant drums or are forthrightly informed that their positions will be declared redundant. Throughout the 1990s hospitals cut back or phased out the CNS role in hospitals all across the country. The need "to change with the times" or "to see the writing on the wall" are commonly expressed sentiments. CNSs have "felt lucky" when their nursing directors "looked out for [their] welfare" by suggesting that they combine the CNS role with that of an NP. Some are fully supported financially to obtain the additional ACNP educational qualifications, while others have staff physicians that assist them in the securing of clinical internship placements. CNSs chose to seize the opportunity before them, seeing it as a chance to learn advanced knowledge and skill as a means to augment their effectiveness as CNSs.

> I just saw this as a growth opportunity to add on to the CNS. It just seemed to be a trend in where all the jobs were. It just seemed to be that people were wanting less CNSs and more NP/CNSs.

Similarly, nurses returning to school for a graduate degree in the hopes of opening up other career opportunities suddenly find ACNP programs being offered to them. Nursing supervisors, recognizing and acknowledging their nurses' desires for more education but a preference for a clinically based position, encourage them to look towards this type of educational opportunity. One ACNP who had been laid off due to the hospital restructuring process, decided to seize the opportunity to return to school for her graduate degree in the hopes of securing a teaching position with the local college. It was her manager who brought a newly created nurse practitioner posting to her attention and encouraged her to undergo the interview process, despite her own reservations and lack of confidence. She was the successful applicant. Other nurses who have left the clinical area in search of new challenges in such positions as clinical educators, managers, and research assistants, jump at the opportunity to return to direct clinical practice when they are approached or supported by their nursing leaders or physician colleagues to create an ACNP position in their area of expertise. For example, one nurse, having become a bit restless in her role as a clinical coordinator, returned to graduate school as a way to challenge herself. Just as she was completing the masters program, nursing administration approached her to be part of a pilot project that would create and implement the ACNP role at her institution. As she related, "somewhere along the way we must have discussed the fact that I wasn't really interested in teaching or administration, and I wanted to take the skills that I had, do something, maintain them, in the clinical area." This new role "was the perfect opportunity" she had been looking for and she felt very fortunate that she had been approached and supported (including financial supports) to train for and then create and implement the role. In another narrative, a physician not only encouraged the nurse to seize the opportunity to become an ACNP, but also made it a realistic venture for her. In addition to making it possible for her to return to school full time while working flex hours in her full time position, he helped to create an environment of physician support amongst all the physicians within the service and then mentored her during the clinical practicum.

> A research nurse is where I started out. ... And then a position was posted for a nurse practitioner in [service]. I go, "man that would be a great job," and I said, "Well too bad I'm not qualified." And he [physician] said, "Well what do you need to be qualified?" I said, "Well it's more schooling, it's two more years". He goes, "Well talk to [physician's name], go back to school. And it had just never crossed my mind that that's what I should do. So indeed I did and I went to school full time and [physician's name] kept me employed full time for the two years.

John Keating, the passionate English professor portrayed by Robin Williams in the critically acclaimed motion picture *Dead Poets Society* (Hoft et al., 1989), exemplifies this notion of seizing the opportunity. Keating inspires his students to live life to the fullest, exclaiming, "Carpe Diem! Seize the day boys! Make your lives extraordinary." This charismatic teacher's emotionally charged challenge is met by his students with enthusiasm, changing their lives forever. Like the boys in this movie, it is as a result of an inspiring presence in their nursing careers that many nurses seize the opportunities that are presented to them to become pioneers and traverse the rich uncharted waters that could be the ACNP role in Canada. The presence of a John Keating, an Athena, or a Chiron, either introduces an opportunity or ignites the flame that facilitates the nurse's attendance to the call, promoting the initiation of the transformational journey to being an ACNP.

> She [nurse manager] must have seen something in me or whatever... and she tried to start me a bit, even though there wasn't a position available.

> I had a great supervisor who was very much into mentoring and into trying to encourage her staff to take on greater responsibility and greater education. She even made it possible for me to go back to school for my master's while still working full time, and allowed me to flex my hours.

Sometimes the opportunity comes in the form of a personal invitation to join the pioneering team. It is the external recognition that twigs them to consider the possibility that they might be able to take on this new challenge. Without the recognition from a reliable and respected source, many doubt they would ever consider such an undertaking, let alone believe that they are capable of such an endeavor. As one ACNP admitted, her first response when she was asked to consider applying for a temporary ACNP position was "to go into the corner to the other nurse clinicians and say – do you think I can do this?" Encouraged by another NP in the institution, this nurse found the courage to test the waters of the ACNP role. This same participant surprisingly shared that she had initially left bedside nursing because of her own lack of confidence in her abilities and an overwhelming fear that she would harm her patients due to a perceived lack of appropriate knowledge and skills. Anticipating that she would have to leave nursing altogether, she had been offered clinical project work, a job that helped her to "see the bigger picture and think system wide." In this position she met others who recognized her potential and encouraged her to return to the bedside as an ACNP. At the time of the interview, she had held this position for nearly a decade.

This story of uncertainty as to one's abilities is not uncommon and once again John Keating's admission to his students in the *Dead Poets Society* articulates this well: "I was not the mental giant you see before you. I was the intellectual equivalent of a ninety pound weakling." Keating's admission of this perception of himself is metaphorically similar to those described by many nurses before becoming ACNPs. Much of nurses' reluctance to consider themselves worthy to take on the challenge of this role involves a lack of self-confidence and recognition of their own abilities or potential. Yet, with the encouragement of others they become willing to explore the possibility of finding the "giant" within. Similarly, the following allegory, which is told in the contemporary movie *Shadows in the Sun* (Mirman, 2006), speaks to the tale of many ACNPs.

> In Italy, there is an old story told about a bird who loved to fly. One day when he was high up in the hill it began to rain and his feathers became so heavy, that when he tried to land, he broke his leg. Time past and the bird became better and it was time to fly again, but no matter how hard he tried, something inside stopped him from leaving the ground. His fear held him there. Then one day a strong wind came and lifted him high into the sky and he spread his wings. A few moments later, he suddenly realized that he could fly.

Learning to seize the opportunity is often as a result of a John Keating personage somewhere earlier in their lives, even in their childhood. As one nurse humorously recalled, with eleven brothers and sisters in her family, she had had to learn to seize the moment "or you're just going to be left by the way side." Others speak to the lessons learned from nursing leaders early in their nursing careers. These leaders are perceived as "all around me, 'wings- beneath-my-feet' mentors," leaders who are "such a gift," and "whose message [is] always, if you believe in something, do it. Don't worry about things, have integrity, but don't not do something because you think that you can't." Inspiring these nurses to dream big, take risks, and to believe in themselves, to see their abilities and their potential, these nursing leaders are the winds necessary to lift the nurses into flight.

I Believe I Can Fly

I believe I can fly

I believe I can touch the sky
I think about it every night and day
Spread my wings and fly away
I believe I can soar
I see me running through that door
I believe I can fly
I believe I can fly
I believe I can fly
If I can see it, then I can do it
If I just believe it, there's nothing to it

~ Etta James, 2006[12]

These Athenas, Chirons, and Keatings frequently support their nurses in challenging the status quo and bringing difficult issues to the forefront. As a result, nurses develop the confidence to enroll in graduate school, pioneer the ACNP role in their institutions, and persevere when the transformational journey becomes particularly treacherous, the obstacles overwhelming, and the number of battles lost outnumber those won. An illustration of this point is the recollections by one ACNP of the John Keatings she had encountered in those early and impressionable moments of her nursing career. As part of her consolidation experience, she spent a month in an outpost nursing facility where she witnessed the expanded role nurse in action. As she pointed out, she had had the opportunity to "see and do things that you would never see and do in an urban area." This experience both fascinated and interested her, while encouraging her to be a risk taker and independent thinker. She also noted that when she started her nursing career as a new graduate she had worked for a "wonderful head nurse" who strove to develop a strong sense of professional nursing identity and patient care responsibility in each staff by instituting primary nursing care, a nursing orientation she believed she would find once again in the ACNP role. Likewise, this same mentor had "a maybe we could" philosophy that this nurse found empowering and helped to "set her up for down the road." This "can do" message is a common one that many ACNPs have heard throughout their personal and/or professional lives, providing them with the impetus necessary to "seize the day" when it finally presents itself and to initiate the ACNP's transformational journey.

> The rabbit-hole went straight down, so suddenly that Alice had not a moment to think about stopping herself before she found herself falling down what seemed to be a very deep well. ... Down, down, down. Would the fall never come to an end? 'I wonder how many miles I've fallen by this time?' she said aloud. 'I must be getting somewhere near the centre of the earth. ... 'I wonder if I shall fall right *through* the earth!' (Carroll, 1865/1971, p. 10-11)

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[12] From James, E., James, S., James, D., & Sklair, J. (Producers) (2006) *All the Way* album. Distributed by Sony BMG Music Entertainment. Lyrics written by Robert Kelly; published by Zomba Songs.

CHAPTER FIVE

BEING ADRIFT

Adrift

tangled in
sinking wreckage
of present.
anchored to
disillusionment
of dying past.
adrift on
engulfing tide
of future
with flagging sails set
in no particular direction.

~ J. C. Justice (2004b)

"In the port is safety, comfort, hearthstone, supper, warm blankets, friends, all that's kind to our mortalities" (Melville, 1851/1992, p. 116). Melville begins his epic novel, *Moby-Dick*, in the safe harbors of New Bedford, a town that exists as a place of departure and return of whaling boats. In the harbor, everyday life is intelligible and predictable. The daily routines and rituals provide a firm earth underneath peoples' feet. Melville suggests that safe harbors are places where people anchor themselves in what is comfortable and secure, in a fixed sense of who they are, either as members of the dominant culture or as the "Other" given a space at the margins. Nursing as known by ACNPs prior to initiating their journey, like New Bedford, is a particular type of community: safe and secure in itself, with most nurses absorbed in the everydayness of their lives. Work life is predictable. Yet in order to grow and develop, to become what they are not yet, and to realize their fuller possibilities, nurses who become ACNPs, like Ishmael, become weary of comfort spaces and are prepared to leave the safe harbor and venture forth. However, once they commit themselves to the journey, ACNPs face many challenges, and just as Melville metaphorically taught us in the narrative of Ishmael's journey, "in the gale, the port, the land, is the ship's direst jeopardy" (Melville, p. 116).

This journey is expected to take ACNPs into uncharted waters, particularly as nurses are currently pioneering the ACNP role in Canada. Figuratively speaking, ACNPs are likely to experience unexpected stops in unknown ports, as well as encounter storms and numerous perils of the sea. Perhaps the journey of the crew of the "Andrea Gail" depicted in the *Perfect Storm* (Weinstein et al., 2000) demonstrates the challenges experienced by ACNPs in *being adrift*. Just as the crew of the "Andrea Gail" held differing expectations of the journey ahead, so also ACNPs come to the journey with differing perspectives and expectations. Most, but not all, are excited about the adventure, and the lure of calm waters and sunny skies on the horizon are exciting. A few are drawn by the power and force of nature, the notion of troubled waters, and the chance to ride the crest of the waves. Yet the journey never holds exactly what they expect no matter how prepared or seaworthy they think they are.

The turbulence experienced during *being adrift* is primarily associated with the clinical management of the patients for whom ACNPs are to care within their subspecialty of practice. Clinical management of the patients requires sophisticated skills, advanced critical thinking abilities, political savvy, and a high level of decision-making, and thus necessitates the ACNPs' full focus and energies. Nurses who embark on the journey are often those who are already confident and may even be expert in their current nursing roles. When they commit to the launch, they must leave the comfort of their nursing practice to enter a new and unknown practice. Leaving this comforting port of competence and entering a new position with different and unknown expectations leads to feelings of "fear" and "insecurity." Because the role of the ACNP continues to evolve over time and is influenced by many environmental issues both internal and external to the practice setting, their journey is just barely beginning upon the completion of their formal ACNP training. Certainly the ACNPs will have had experience as a student in making diagnostic and treatment decisions. However, as noted by Buehler (1987), these are made as a "guest" in training sites and with full recognition that they are, after all, only learning to make such decisions (p. 50). The new ACNP faces the major tests of their clinical judgment in their first positions. *Being adrift* then is a time of transition.

Brown and Oshansky (1997) first described the transition to the NP role in a theoretical model based on grounded theory methodology that examined the experiences of recently graduated NPs during their first year of primary care practice. The model consisted of a process called *From Limbo to Legitimacy*. Nurse practitioner graduates were described as "being in limbo" because they had the academic credentials but not the necessary license or employment to practice as an NP. But being in limbo, what I term here as *being adrift*, concerns much more than credentials.

All of us have experienced transitions - moving from grade school to high school, leaving our parent's home, getting our first job as a nursing graduate, getting married, becoming a parent for the first time – and know that they are often filled with turbulent and ambivalent feelings. This is not to say that some transitions can and do go smoothly and may be so gradual as to be almost imperceptible. The word transition is derived from the Latin word *transire* (from *trans*, across, and *ire*, to go) meaning to go across or pass through (Barnhart, 1988). As such, the word embraces elements of time, movement, and even perception, for the meaning of a transition relates to the person experiencing it. This sense is reflected in the first meaning given in the *Oxford English Dictionary* (Trumble & Stevenson, 2002): "a passage or movement from one action, condition, or place to another; change being an instance of this." It is also reflected in the word *transient*, which means a passing away with time or passing through a place without staying in it or staying for only a short time. There really is no expectation or intention to stay in this time or place.

By its very nature, *transpire* means to pass away, which is most frequently understood when we speak to the transition from this life to the next by death. In this respect, there is a passing away of part of oneself, part of one's identity. Consequently, a transition results in an emotional journey during which the individual must leave behind old ways of being and let go of the identity associated with those ways. Paradoxically, a transition starts with both a beginning and an ending. For example, with the arrival of a new baby, the beginning of parenthood, a mother has to let go of regular sleep, of extra money, of time alone with her partner, and even time alone period. And, there is nothing that makes her feel like she has lost her sense of competence more than being faced with a baby who refuses to eat or will not stop crying. But redefinitions of self and the situation cannot occur until there is a passing away of the old definitions of self.

Being adrift, a time of transition, should not be confused with psychological models of grief and loss work. Rather, the work of cultural anthropologists Van Gennep (1909/1960) and Victor Turner (1969, 1974, 1984) on the *rites de passage* can help us to find meaning in the ACNPs' experience of *being adrift*. Van Gennep in his book *The Rites of Passage*, which was further explored and developed by Turner, distinguished three stages of transition. During the first stage, a person is separated from one status in society. This results in a marginal and liminal state or state of ambiguity, the second stage, which has none of the attributes of the past or coming state. However, after an initiation, the person is finally reintegrated into the social structure in a newly achieved role-status, the third stage. Drawing from this model, what is experienced by ACNPs during the time of *being adrift* is a sense of *being disconnected* or removed from the nursing community of practice with which they are most familiar, people they know, their usual routines. In *being disconnected*, there may be both a physical and mental separation, but in many cases, there is simply a mental separation while still engaging in some of the regular nursing activities. This literal or symbolic removal from normal patterns sets up the ACNPs' experience of marginality or liminality.

Liminality has its etymological connections with nouns like limit, limbo, limbus, lintel; with verbs like limn, delimit, and eliminate; and with adjectives like preliminary, sublime, and subliminal (Barnhart, 1988). As the Latin term *limen*, meaning threshold or boundary, implies, the ACNPs find themselves living in a threshold between two spaces, a space and time of being "betwixt and between" social categories and states of being, what Turner (1969) referred to as "threshold people." The state of ACNPs as "passengers" in this journey through liminality is ambiguous, neither here nor there. Liminality is imaged as "a place that is not a place, and at time that is not a time (Turner, 1974, p. 239), like being in a tunnel between the entrance and the exit (p. 231). The demigod Chiron, previously mentioned as an example of support to ACNPs throughout their journey, is a classic example of the liminal image. Both man and stallion, with no fixed status, Chiron was fated to wander the earth in this state of limbo. Nevertheless, he taught the sons of kings and princes the arts of civilization and healing. Despite being liminally outside, he was a source and strength of social order (1974, p. 253).

The liminal state incorporates a time and space where ACNPs are passing through a threshold or are in a transient position (from being in a nursing position assigned traditional laws, customs, and conventions, to being in an ACNP position that has new and different laws, customs, and conventions). The liminal state is a "scared condition in and out of time, where bonds between people ignore, reverse, cut across, or occur outside structural relationships" (Schroeder-Sheker, 1994, p. 92). Liminal activities tend to be extreme; they appear strange and sometimes disturbing and dangerous to those living and working in the regular routines and following socially accepted rules (Turner, 1974). Since this liminal state is an inter-structural situation, unclear and contradictory, ACNPs are apt to be perceived as being "contaminated," or impure, looked on as aberrations, disturbing, and even a threat to the status quo (Turner). As a result they do not always have the support of their communities as they make shifts from being one type of person to another. This only accentuates the experience of *being disconnected*.

During the liminal period, ACNPs pass through a space that has few, or none, of the attributes of either the past or the future. *Liminal personae* – that is, ACNPs on or in the threshold – necessarily live with the experience of *being uncertain*. "Lu-minality," said Turner (1974), "is unsettled and unsettling" (p. 274). As a result of being in transition or occupying a transient position of liminality, *being adrift* is characterized as a time of turbulence. Heitz, Steiner, and Burman (2004) defined turbulence as "alternating emotions and perceptions with an overall range from easy to difficult and many in-betweens" (p. 417), not unlike the ebb and flow of the ocean's tide interspersed with the gigantic waves that come with raging storms. Turbulent tides are commonly experienced by ACNPs as feelings of insecurity, disequilibrium, disorientation, anxiety, apprehension, and disorganization, along with the numerous and varied feelings that come with the loss of relationships, confidence, and control. *Being adrift* means being immersed in an experience of feeling "overwhelmed," "inadequate," "vulnerable," and "confused," all feelings associated with the lived experience of *being uncertain* at a time when there is an intense awareness of being responsible for the protection of others. *Being uncertain* comes from the loss of previous reference points, abilities, and activities; the disruption of relationships and roles; incongruity between access and needs; discrepancy between what is anticipated or hoped for and what actually evolves, along with few or no ACNP role models. *Being uncertain* heightens the ANCPs' feelings of isolation and loneliness experienced as a result of *being disconnected*; a time of waiting for that which is not yet known.

Transitions involve going through an in-between time and place when the old is gone but the new has not yet been discovered (Turner, 1969); a no-man's-land between the old reality and the new one. A transition is the limbo between the old sense of identity and the new; a time when the old way of doing things is gone but the new way does not yet feel right or comfortable. A situational change happens when nurses move into the job entitled ANCP and begin to engage in the new activities of performing detailed history and physicals, making medical diagnoses, and prescribing treatments. However, the internal changes happen much more slowly. As a result, many ACNPs find themselves struggling in a kind of emotional abyss, a time when they are not quite clear who they are or what is real. ACNPs experience this transitional period as a time of *being lost* because, as Julia Kristeva (1982) argued, order and identity are disrupted. They experience emotional suffering and intense vulnerability as a result of taking on the characteristics of a persona that has no classification, for "it is as though they are being reduced or ground down to a uniform condition to be fashioned anew" (Turner, p. 95).

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One may be tempted to view the tumultuous nature of the ACNPs' journey as purely negative as they continuously struggle to endure the storms and shark attacks during this time of *being adrift*. Yet, looking at Winslow Homer's painting more closely, he has bathed the lone man and boat in light, nested in a trough of waves. The man appears to be strangely calm as he rests on his elbow, even as his mind is alert as he looks for ways to manage the situation. On the horizon, there is both light and the outline of another boat. Painful though it may be, the experience of *being adrift* is the ACNPs best chance to be creative, to develop into what they need and want to become, and to renew themselves. *Being adrift* is a time when, in *struggling to stay afloat*, innovation and revitalization is possible. *Being adrift* is thus both a dangerous and an opportune time, and is the very heart of the journey. *Being adrift* is a time when ACNPs are introduced to new and special knowledge not previously accessible; a time of rapid and extensive learning and growth. But as a result of the passage through the turbulence of *being adrift*, new beginnings can emerge and ACNPs can begin to experience a transformation of identity, find new energy, and discover the fit for which they are searching. A willingness to enter into the dark void of the unknown, the fertile womb of disorientation and distress, always gives birth to the next knowing. In *being adrift*, ACNPs have a perfect beginning for the process of transformation or metamorphosis because *being lost* is just what is needed in order to properly prepare for the experience of being found.

The ACNPs' experiences of *being disconnected*, *being uncertain, being lost*, and *struggling to stay afloat*, all elements of *being adrift*, do not follow a linear pattern, nor are they necessarily limited to a single time in their journey to becoming and being an

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[13] *The Gulf Stream* by Winslow Homer (1889) licensed under a Creative Commons License. Retrieved August 4, 2006 from http://www.mythfolklore.net/3034mythfolklore/reading/alice/images

ACNP. ACNPs experience these elements recursively, each ACNP weaving his or her unique design in the cocoon of change. In this respect, as well as being "a space in its own right" (Froggatt, 1997, p. 125), transition is also a process of becoming, a mode of being. Similarly, Van Gennep (1909/1960) and Turner (1969) argued that the stages of separation and liminality are not necessarily equally important or equally elaborated when experienced in the various transitional experiences that human beings undergo in their lives. Their use of the word "stages" gives the impression that a transition is a linear process, yet for ACNPs, these constitutive elements of *being adrift* do not happen separately or discretely. In fact, they most often go on at the same time and involve a complex, iterative, to and fro movement, embedded within a specific context-person-environment interaction.

Being adrift may take years, is not a single or simple initiation, and involves numerous experiences, each of which refines the outlook and lives of those engaged in the journey. The meanings attributed to the transitional experience in *being adrift* are affected by such factors as the catalyst or call for the change, the individual's emotional and physical well-being, the individual's level of knowledge and skill preparation, the environmental resources and support, and the expectations of others who are in fact themselves in transition. In fact, an ACNP's transitional experience is part of a whole matrix of transitions taking place simultaneously. For example, a nurse's transition toward becoming an ACNP is accomplished in relation to both the staff nurses' and their medical colleague(s)' transition to the presence of the ACNP, the nursing profession's transition to this particular advanced nursing practice role, and societies' transition to this new health care provider. And finally, by its very nature, there is a mystery in what occurs during the "hidden" marginality/liminality state. It is as if *the rite de passage* recognizes the cocoon state in which changes occur but does not reveal the activity within the cocoon. To further understand the metamorphic changes that eventually are revealed, what happens in each of the elements of *being adrift* will be explored separately.

Being Disconnected

> *I am like a flag by far spaces surrounded.*
> *I sense the winds that are coming, I must live them*
> *while things down below are not yet moving;*
> *the doors are still shutting gently, and in the chimneys is silence;*
> *the windows are not yet trembling, and the dust is still heavy.*

Then already I know the storms and am stirred like the sea.
And spread myself out and fall back into myself
and fling myself off and am all alone
in the great storm.

~ Rainer Maria Rilke[14]

In *Being Called to Be More,* nurses who choose to become ACNPs are disenchanted with nursing as practiced in the traditional model, feeling as if there is not a "perfect fit" with what it is they are doing. ACNPs begin the separation from mainstream nursing with this recognition and willingness to initiate the journey. This is followed by a return to school and/or the attainment of an ACNP position in the acute care clinical setting, where they begin to become indoctrinated in the knowledge, skills, attitudes, and values of the ACNP role. This advanced level of knowledge and skill causes a detachment from the earlier fixed point of being nurses in the traditional realm and, as noted by Van Gennep (1909/1960), creates the experience of *being disconnected* from what they know, who they are, and where they belong.

To establish a role that is their own, it is necessary for ACNPs to become distant from other nurses and physicians. As a result, there is an emerging sense of not really being part of either group. ACNPs feel like they don't fit anywhere. They are "straddling two identities while not feeling a part of either" (Brown & Olshansky, 1997, p. 47). Rather, there is a sense that they have been turned out from the "proverbial center of an experience to its periphery" within nursing (Boychuk Duchscher & Cowin, 2004, p. 290). There is also a strong realization that they will never be accepted by medicine except on the outer edge of the medical experience. As a result, ACNPs live simultaneously in two worlds, "the borders of which are seen as being mutually exclusive and even diametrically opposed, while at once dynamically permeable" (p. 290).

Although many ACNPs admit to having "horror stories about those nurses who eat their young," they hold great regard for their fellow nurses and speak about them and nursing with affection and loyalty. This is apparent in the jovial social atmosphere they describe as missing, particularly on nights and weekends, when there is a more relaxed and informal environment. They miss the support that nurses give each other through difficult times. Change in their role brings about the loss of old ways of being with nurses that comes from working side by side, doing the same type of work, taking breaks together and sharing stories in which there is a common sense of purpose and loyalties.

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[14] An excerpt from the poem *Presentiment*, published Norton, H. M. D. (1938). *Translations from the poetry of Rainer Maria Rilke* (p. 79). New York: Norton.

"Going from being at the bedside and then coming back and being part of the team, but not really part of the team in terms of being at the bedside because [they've] flipped sides to giving orders," results in a sense of alienation. A special collegiality has been lost and many ACNPs experience a sense of loneliness and grieve the loss of these previously taken-for-granted relationships. There is a sense of no longer belonging, a sense of loss of acceptance by the community of practice to whom they had once been strongly connected. With the realization that they have inevitably been changed in the process of becoming ACNPs, they also understand that there is a permanency to this loss. As T. S. Eliot (1959) wrote, "Fare forward, travelers! not escaping from the past into different lives, or into any future; You are not the same people who left that station or who will arrive at any terminus" (p. 41). Even if they should quit this new role (a thought that often passes through their minds during the time of *being adrift*), the acquisition of new knowledge and skill means they are no longer the nurse they once were.

> And then just knowing where to fit in with your peers. And, you know, one day you're with them at the bedside and you're part of the team whereas in the ACNP role you're a separate entity. And although you're autonomous, it's also very lonely, because you never work really closely with the other team members, and so there's a sense of loneliness as well. And that's a big transition of the letting go of being like a real, I don't know, I mean we're still a member of the health care team, but there is a difference from being at the bedside working with two or three nurses. And so there's a sense of loss with that as well.
>
> But you go through separation, the letting go. I guess it's more like grieving of a secure position that you were in. And yet the challenge and the excitement and the opportunity of a new role still keeps you, has your appetite wet with curiosity and wanting to develop those skills and have those learning opportunities. But at the same sense, it's part of you that you were good at, and you are still good at, or I was still good at, but just along a different pathway. And it was sad to let go of it, to not be part of that team in the same sense of the intricacies. I mean you can still, you still help out, but you're not ultimately responsible for that one patient or, you know, when you're in a room the dynamics of working with three or four other nurses and doctors and family members, that you don't have that, you're always on the periphery.

Being disconnected is like being anchorless, a feeling commonly experienced by ACNPs in this time of *being adrift*. Lacking a structure and not knowing how to embrace the independence, how to handle the responsibilities of their own learning and autonomy, or even how to structure their time, contribute to this feeling. As one ACNP reflected, in traditional bedside nursing, shifts are structured around the "to do" list of activities that are engrained in us from our first days in clinical practicums. Using the reified Kardex, nurses have learned to organize their day through a framework of patient care activities scheduled into hourly allotments that help them to grasp the clinical situation in a meaningful way. In this manner, they can know what must be done for the patients in the time that they are within their care. In this way, they come to know what they do and who they are. But in this new role, the ACNPs' sense of *being disconnected* is heightened by *being uncertain* as to how to even structure their days using the autonomy given them.

> The independent practice part of it was the biggest piece. You know as a bedside nurse you come to work, and you know exactly what it is that you are going to do and that sets your frame work for how you'll organize your day in terms of -okay, I'm going to do vital signs every two hours; I have these meds to give; I'm going teach the family this and, you know, look after the patient. And there are certain checks and balances that get you through your day. So at the bedside I considered myself probably an advanced to expert bedside nurse, but then going into a new role where it wasn't quite clear in terms of - Oh I don't have that anchor of having a patient assignment with specific tasks. What does that mean? There were no real roles and responsibilities written to clearly define – Okay, today I'm going to come on and every two hours you're going to do this, this and this. …It was fairly loose, and that independentness and having to be responsible for my own autonomy and my self learning activities was really new for me at that time. So trying to organize my day and people trusting me to be accountable for my hours. And so being given that autonomy wasn't something I was used to and so that autonomy piece was probably a bit of a transition.

Some ACNPs are instructed by nurse managers to refrain from "wearing a uniform," "answering bells," or "helping other nurses in the giving of patient care" in order that the ACNP role can be differentiated from that of the traditional staff nurse role. Despite their desire to demonstrate to the nursing staff, patients, and families that they are both capable of and "not above" engaging in traditional nursing functions, some ACNPs see wisdom in this advice. Therefore, they disconnect themselves from activities that are both familiar and provide them some sense of purpose and meaning. Others remain engaged in these activities, recognizing that if there is a patient need "right now and there's nobody else around," then "everybody must put their hands in the work that needs to be done." They identify that the priority "must always be the patient," not "what tasks are assigned to each person." Yet even these ACNPs acknowledge the internal and external tension created when they realize that they must sometimes turn away from assisting nurses with hands-on patient care, turning instead to their own tasks that are of equal importance and priority to patient well-being. And so there is a sense of grieving that which is familiar.

Similarly, the simple fact that ACNPs "spend the majority of their day and the majority of their time interacting with staff physicians, fellows and residents," "even eating with the doctors," and "socializing with them in the wee hours of the morning as they wait together for the new patient to be admitted to the unit," can lead to the feeling that they are "leav[ing] the bedside nurse in the background." This loss of a sense of belonging to a community of nurses and the grief that is experienced as a consequence is palpable in the following illustration of an ACNP still struggling four years later to reconnect with her nursing colleagues within her practice.

> I guess just to reconnect with nurses is part of what needs to be done. And I'm not sure what that means or how to do it exactly. I mean we sometimes do these little education things and that helps, but there's more to it, and I'm not sure exactly what it is. But it's like you take a step up from bedside nursing if you will - I'm not sure that it's up, or if it's just over, I don't know - so you make this change, and you kind of just abandon nurses, maybe not nursing, but nurses. There has to be a way to integrate the two better. And we don't even eat in the nurses' lounge and I don't know what that means either, but it's just there [heavy sigh]. And nothing would happen if I stopped eating with the residents and ate with the nurses. No one would say anything. They might say, "Where were you at lunch?" And the nurses might kind of look at you but they wouldn't say anything either and they certainly probably wouldn't make me feel like I didn't belong there. But I have no idea if it would change their conversation at break time or not. I don't know if you're really so different that you would influence conversation or if you're really not that different in their eyes. ...I miss it when it comes time to have like social activities you know, their social things, and you're not sure, you know, if you should go or not. And you don't want to rain on anyone's parade.

How are ACNPs to re-establish their relationship with Others in this new role? Who are they to align themselves with to feel connected to in their role as ACNPs, a role frequently established as an N of one within their subspecialty practices? Wenger (1998) stated that in order to do one's job, individuals must align their activities and their interpretations of events with structures, forces, and purposes beyond their community of practice and so find their place in broader role processes. Yet during this time of *being adrift*, particularly as a result of being pioneers, this does not occur because structures are not yet known and understood, if indeed they are even in place, and a sense of purpose has not yet been discovered. Turner (1974) suggested that individuals experiencing this in-between status tend to form a "community of passengers" where they experience what he calls communitas, the spirit of comradeship and fellowship amongst those undergoing the same transition. But how can ACNPs develop and/or sustain this sense of "being all in this together" when, for many of them, they are a single passenger on the journey once they leave the educational setting?

> There were two or three primary NPs in the hospital but again they were very busy and so it was hard to speak to similar events, or, it just wasn't the same. I don't know how you describe that, but it just would have been helpful to have had someone who's been there and done it before and knew exactly what you were experiencing. Because some days you'd go through it and you'd think, "Am I loosing my mind? What am I doing here? ...Everything is just all jumbled up and sort of that overwhelmingness and feeling so all alone.

If ACNPs so frequently work in isolation, can this experience of *being disconnected* be a transient situation, a time-limited experience of passing from the center of one cultural group to the center of another? Or, are ACNPs destined to find themselves in a more permanent marginalizing situation as a consequence of the context of their practice environments? Perhaps the expression, "I am afraid I'll miss the boat" so commonly utilized by many ACNPs, takes on a new meaning when one considers ACNPs are no longer "in the same boat" with other "liminal beings." Instead, ACNPs experience a loss of identity since they are neither a traditional nurse nor a physician; rather, they are members of a unique group who are neither understood by other health care providers nor society in general, and who have no place or status.

> When I was a bedside nurse I found that the relationship with the family was significantly better because you're there all the time and you're comforting the patient and they're seeing your interactions with the patient. As an NP when you come along and you talk to the families, it's more an information-giving session, a question-answering session. ...And I struggle with that whole thing because if the patient's family is wanting information, they're often wanting it from the doctor, or wanting it from the surgeon, and they're not happy talking to you because you're not him. And for starters, most families don't even know what an NP is. ...And so it's that whole thing about where you fit in because you're not with the patient all the time and you're not the doctor, so who are you really?

This sense of "being part of the team, but not part of the team," "being in a place all of your own" that has no meaning, extends beyond the immediate care of the patient to a sense of not belonging to any group, particularly in nursing, within the organization. As one ACNP noted, "though you may be situated in the nursing leadership team, you're not really, because they all do their meetings about their budgets and their policies and this and that which doesn't impact us at all."

> It's hard because you should be, from a clinical perspective, on the physicians' team, but they've got their own little intensivist team too. And so there's many teams in which you take part, but you're not always a part of. You're just a part of them when they think you should be a part. And so it's sort of like floating in your own little space.

ACNPs are also often unknown to each other and as such feel disconnected from their own genre of nursing. As one highly experienced ACNP lamented, "I still want to go and talk to someone, another NP. It's been something I've been wanting to do for a long time, to just work with another nurse practitioner for a week or so, because I never did work with anyone and I'm sure I could learn a lot about being a nurse practitioner." Even if they are not the only ACNP, they often lack the time to invest in close relationships with their colleagues or to develop connections with other ANCPs within their work settings. Many work within institutions where administration provides limited to no opportunities for ACNPs to get together and/or they are not supported by nursing management or their physician team in leaving their clinical responsibilities to attend meetings. Nor do ACNPs have the energy to initiate a support group that can help them work through their feelings during this period of time. A few ACNPs speak to joining established local advanced nursing practice groups usually founded by CNSs; however, they find at this period within their professional development as ACNPs that there is virtually no connection to what they are experiencing in their clinical practice with what is being discussed. Once again, they can find no sense of meaning or identity as ACNPs within this particular structure at this juncture in their journey. The paradox of this experience is that as ANCPs' strive to carve a unique role that allows them to be more autonomous, more in control, and more connected, the very nature of these goals seems to highlight and heighten the experience of *being disconnected.*

In describing the barriers to the acceptance of their role as ACNPs, the relationship with physicians, nurses, and other health care providers inevitably surfaces as an issue and serves to alienate ACNPs within the context of their practice environment. Support, encouragement, and assistance from professional colleagues are expectations learned from past experiences but are not always present in this role. Feelings of loneliness, vulnerability, anger, and frustration result from a lack of support, encouragement, and assistance. These feelings augment the experience of *being disconnected*. Despite the findings in the literature that have consistently identified this as a problem (Brown & Draye, 2003; Heitz et al., 2004), the degree of resistance and resentment, along with the depth of antagonism they experience from nurses, inevitably takes ACNPs by surprise. They frequently express that they "just didn't see it coming." With alarming consistency, ACNPs describe senior staff who lack care and concern for them, and who verbally abuse them. How are identities shaped when ACNPs' are forced to "wrestle" with the outright hostility they encounter from some of their nursing colleagues as they try to begin to practice in their new role? How does being labeled a "scut monkey" by another nurse shape how an ACNP sees herself? When bedside nurses challenge who they are and what they do in front of patients and families, or refuse to acknowledge the orders that they write, how does it affect their self-worth and their sense of being valued as ACNPs? Experiences of outright ostracism and criticism highlight their lack of acceptance and being different from the *norm*.

> And right in front of the patient she's like, "So what do you think you are? Do you think you're better than everybody else around here? So if you think you're better than other nurses, is that why you're doing all this doctor stuff?"
>
> When I started here I couldn't play in the same sandboxes as my colleague who'd been in the role for ten years. I'd be checking lab work and find abnormalities and come out to, you know, write orders to correct those and find that the nurse had already paged the resident; she didn't think of me. ...There'd be meetings held and you'd find out about them

> afterwards or there'd be parties and everybody would be talking about them and you weren't invited. And nobody even explained why you weren't invited.

The word ostracize is derived from the Greek words *ostrakon* and its relatives, *ostreon*, 'oyster', and *osteon*, 'bone," name hard, brittle objects (Barnhart, 1988). The *ostrakon* was a shell or a fragment of pottery that served ancient Athens as ballots in a particular kind of popular vote. Every year the citizens had the right to gather together to vote for the *ostrakismos*, or temporary banishment of anyone whose power and authority threatened the equilibrium of the state. Each voter recorded a name on his *ostrakon*. If at least six thousand votes were cast and if a majority of them named one person, then that individual was banished or ostracized (Flavel & Flavel, 1995). Six thousand votes are not necessary to elicit the feeling of exclusion from acceptance by the group of nurses with whom ACNPs work. The words and actions of just a few of their nursing colleagues serve to be as hard and brittle in their effect as the *ostrakon*. Bedside nurses are in a central position to help ACNPs function more efficiently, but they can also undermine the ACNPs' confidence and effectiveness. Certainly, these types of encounters enhance the ACNPs' sense of separation, of being an outcast, of being cast away from the clan, and contribute to their experience of *being disconnected,* while prolonging the sense of *being lost* as to who they actually are in this new role.

> Sometimes you would see a bedside nurse going with the order I'd just written and going directly to the fellow and question the fellow. Or putting the orders aside and waiting for the staff physician to be around.

> Well nursing staff at the beginning weren't too sure how to accept a nurse in that role. It was different. It was new. And so in the beginning some of them were very rude. And I don't know if it was a sense of their being angry at someone else having the opportunity. I don't know if it's the 'we–they' or I don't know what you would call it. It took about, I guess probably I would think about five years before the unit actually valued the role and had respect for its uniqueness. And some of it was a lack of understanding of what it was and the added skills opportunities and the implications of those. And so you'd have nurses in the unit saying, "Oh they always get everything. They're very specialized." And yet it was a choice that was given to everybody and not everybody chose to go into that specialty." But again it was just the respect of the role. And so maybe that's just a felt need that you need to be valued in the position before you get that sense of security and ownership to a new role and the letting go of the old one. Or, not the letting go, it's incorporating it. It's putting it, placing it, incorporating it into your role, the diversity of your role as a nurse.

ACNPs readily admit that they come into the workplace unprepared to assume the full scope of the direct clinical practice component of the role, especially in the subspecialty for which they will be responsible. Key to the successful development of competence and confidence is the support and encouragement of physicians. In addition, physicians, especially the staff physician(s) to whom they report from a clinical management perspective, are essential in helping to establish their credibility with others. In the absence of nurse practitioner role models and mentors, ACNPs are totally dependent on the close clinical supervision of the physicians who either lobbied for or at least agreed to incorporate this role into the compliment of professionals providing medical care to their patients. Expending so much energy trying to master the base of knowledge underlying the components traditionally identified as medical practice naturally causes ACNPs to lose sight of the knowledge underlying the science of nursing. This phenomenon was also described in research examining the family practice of primary health care nurse practitioners (Anderson, Leonard & Yates, 1974). ACNPs become obsessively task oriented which, for a period of time, becomes an end in itself. For months and maybe even several years, they describe "being the physician's shadow." Spending large amounts of time alongside the physicians immersed in the diagnostic and therapeutic activities of medicine naturally results in their nursing identity being submerged, further augmenting a sense of *being disconnected* from nursing.

But how can ACNPs who are "attached at the hip" to their medical colleagues feel so disconnected or marginalized from this group, even as they feel "lucky enough" to be fully supported by them? Why do they not become the centre of the physician's social environment? ACNPs are foreigners to the medical world; invited by some and denied entry by others. As such, they will move from the centre of their experience to its periphery, but being pioneers and lacking ACNP guides, they are unsure of the dimensions of the practice in which they are involved and therefore even have difficulties identifying the borders.

> He who wants to use a map successfully has first of all to know his standpoint in two respects: its location on the ground and its representation on the map. A foreigner has to face the fact that he lacks any status as member of the social group he is about to join and is therefore unable to get a starting-point to take his bearings. He is, therefore, no longer permitted in considering himself as the centre of his social environment, and this fact causes again a dislocation of his contour lines of relevance. (Schultz, 1971, cited by Wu, 1991, p. 269)

Perhaps it is also because, at this point in time, ACNPs are still in the traditional one-down relationship with the physician. Anderson et al. (1974) argued that without their own nursing base of information, philosophy of care, standards and rationale (which have been temporarily set aside during this phase of learning), ACNPs are at the mercy of the physician, who remain in total charge of patient care. As a result there cannot be a sense of truly being connected with their medical colleagues.

The social and political climate, both internal and external to the organization, continues to evolve and it remains unknown how this evolution will influence the presumed potential for movement between subordinate (nursing) and dominant (medical) worlds. This "not knowing" predicates an uncertain and unfixed acceptance of, and full functioning within, the confines of their world as ACNPs. As a point of illustration, in the province of Quebec, there is no legislation that grants ACNPs the authority to write orders within acute care institutions. In addition, the concept of medical directives, which facilitates at least some degree of autonomy in their practice in the provinces of Alberta and Ontario, is currently non-existent. Therefore, ACNPs in this context are able to assume little of their potential in their new role and consequently their view that ACNPs are marginalized is sustained. How can they ascend to their full sense of self when they there is a realization that they are being prohibited? Moreover, although they may be allowed to engage in some of the traditional functions of the medical cultural group, there is an acknowledgment that ACNPs are not, nor will they ever be, at its center. As importantly, ACNPs do not want to be.

But support from physicians is not always present. Most ACNPs describe at least a few episodes where physicians have been antagonistic and unwelcoming toward them. Worse yet, some reveal being consistently and blatantly ignored and left on their own "to sink or swim." At minimum, frustrations and anger flourish. Particularly frustrating are those occasions when NPs seek physician consultation, but are refused or bypassed in preference to speaking directly with a resident or the staff physician, making them feel invisible and ineffective. Physicians who fail to return their calls, and surgeons or anesthesiologists who state, "I cannot give my report to a nurse, I need to speak to the doctor to give the report" complicate the ACNPs' efforts at managing the patients' care. Some feel like second-class citizens when they are continuously exposed to an appalling lack of respect. This is an experienced outcome when physicians do not attend medical rounds if the ACNP is scheduled to present, or they are refused admittance to resident teaching sessions concerning the ACNPs' subspecialty service.

For a few ACNPs this initiation to the role leads to depression as they struggle to not only feel valued but also to be visible, all the while working hard to keep their heads above water so that no harm will come to their patients. Certainly, under these circumstances, this part of the journey is experienced as chaotic, painful, and even traumatic. As a consequence, *being disconnected*, with the accompanying feelings of vulnerability and alienation, are even more accentuated and prolonged. This becomes painfully clear though an incident shared by an ACNP who, after two years in her current ACNP position (but four years as an ACNP), was only just beginning to feel a sense of belonging to the team.

First Neighbours

The people I live among, unforgivingly
previous to me, grudging
the way I breathe their
property, the air,
speaking a twisted dialect to my differently
shaped ears

though I tried to adapt

Go back where you came from

got used to being
a minor invalid, expected to make
inept remarks,
futile and spastic gestures

Finally I grew a chapped tarpaulin
skin; I negotiated the drizzle
of strange meaning, sit it
down to just the latitude:
something to be endured
but not surprised by.

Resolve: to be both tentative
and hard to startle
(though clumsiness and
fright are inevitable)
in this area where my damaged
knowing of the language means
prediction is forever impossible

~ Margaret Atwood, 1970/1997

> I didn't have any neurology background when I started but I said to them, "I can give everything you want but I can't give you clinical neurology." And they said don't worry; we will provide this and this, and I was promised some clinical mentorship from the physicians. ...So when I get there, I'm in the operating room, I get paged for my first consult and I'm told by the person who's suppose to supervise or direct the inpatient care, he says to me, "I'm really sorry but I don't review consults with you." And I said, "Well who's going to?" He said, "That's a very good question." So I was stuck. But I was so new, like I was just in a different world and a different language, it was really very different. And so from September until March, that's about six, more than six months, I tried various strategies of helping me learn. And I was unsuccessful. And then I went to my boss, I'd been going to a meeting with her every few weeks and then monthly, and, you know, she said to me, "To learn neurology, go to Dr. X's clinic." So I would go to the clinic and he would say, "Well I have a medical student and I have a resident and I only like two learners at a time." So I would say, "Well can I round with you?" Well my office wasn't in the area and they would never call me. It was awful. Like it was really awful. ...And then I would try to go on rounds with another group and they would completely ignore me, or they'd say we're going in five minutes, and then I'd be there, and they would have already gone. ...I have found nobody to open doors for me in this new job. I had to do everything myself and sometimes the doors were really shut in my face. ...And it was awful. ... I wasn't sleeping; I had to take more sick days in the first year of this job than I had in twenty-two years. I was on antidepressants. It was bad. ... But I think one of the good things about being an NP is to have assertiveness, communication, you know, critical thinking, to be able to look at the bigger picture, to come up with solutions. ...And I was determined they wouldn't break me.

How do ACNPs reconstruct their identities when those with whom they need to be connected refuse to acknowledge their presence? How do ACNPs reach out for assistance, thereby exposing their naiveté and ignorance and risking the acceptance and connection they so desire, when they are also struggling to find more visibility, autonomy, and control? How do these neophyte ACNPs focus on meeting their own needs while attending to the ever-demanding but unpredictable and unfamiliar needs of their patients at this advanced level?

The focus of the ACNPs' learning at this point is necessarily the medical agenda, "being way too busy clinically just trying to get all the things organized" and learning how to apply the knowledge and skill learned in school independently to their practice. They are too filled with anxiety and fear in the clinical management of the patients as they move away from competence in their previous role toward competence in the ACNP role. As a result of this intense and narrow focus, they have "no time to be present with the patients and families" in the way they would prefer, leaving them with a feeling of *being disconnected* from the patients and families in a way that brings their practice deeper, significant meaning. The search for the "fit" of *being more connected* in their nursing practice, which they hoped would be found in the ACNP role, seems more distant and illusive in this time of *being adrift* than it had ever been in their traditional nursing roles. The resulting turbulence they experience leaves them questioning their choice and reminiscing about that which they have left behind.

> It is possible to feel or recollect the satisfaction of caring for someone, of finding all the little pieces of comfort that were important to that small child, that very elderly person – a mixture of words and silences, of favourite food and drink, of hard work in cleaning up a wet or dirty bed, of special ways of doing things. All the senses involved; the cared-for looked good, smelled sweet. Yet the pleasure did not just belong to the carer; it belonged to the cared-for; at best it was mutual.
>
> ~ Hilary Rose, 1994; p. 39 cited by Wicks (1998)

> I just don't have enough time. I'm too busy doing stuff. Like I find I miss bedside nursing. ... Like when I walk in sometimes when I'm doing rounds, I get jealous, or I don't know what the word is, I guess jealous, and I see the nurses and they're playing beads with little girls or doing puzzles with them and it's like, "I want to do that again," because they're communicating with the little girl and they're talking to the mom and teaching her how to give the Septra, and I'm ordering the pills, and I'm doing the spinal tap, and she's telling her, "You're going to be okay." I want to be on the other side of the fence again and be that comforting person at the bedside again, and to put the cloth on her forehead.

Feelings of marginality and thus *being disconnected* are also a direct consequence of frequently being involved in defensive encounters, situations that force ACNPs to defend their role to others, including colleagues, patients, and their families. "You're as good as a doctor." "Are you my resident today?" "Well, you're ordering things; you're prescribing things; you're diagnosing. Look at the number of years you've spent in school with your Masters. Why didn't you go through to be a doctor?" How does one retain a sense of connectedness to nursing when others identify the ACNP role as belonging to medicine? Do these questions devalue the nurse in the ACNP role? What is the meaning of these questions when nurses in the ACNP role are living through the ambiguous nature of this not-yet-clearly understood role? Many ACNPs clearly acknowledge how they had little concept of what being an ACNP was going to look like. We have been told that as pioneers, most ACNPs have been encouraged to pursue the NP role and/or NP education by either physician colleagues or nursing faculty who recognized their outstanding potential. Few ACNPs had seen an NP in practice in the acute care setting. How can they feel connected to that which others clearly do not understand and they themselves cannot yet clearly articulate? During this time of *being adrift*, ACNPs feel like they are in a foreign place, a place where everything is no longer familiar, and from which little comfort can be taken. We know that the familiarity with what one does creates a feeling of being at home and this familiarity is a source of comfort; one feels "at home;" "one belongs" in this place. But in the daunting and alien world of their new practice, ACNPs no longer feel "at home;" instead they experience a sense of being "out of place." Rather than feeling the comfort of belonging, ACNPs live the experience of *being disconnected*.

Being Uncertain

> The fourteenth of August was the day fixed upon for the sailing of the brig Pilgrim on her voyage from Boston round Cape Horn to the western coast of North America. As she was to get under weigh early in the afternoon, I made my appearance on board at twelve o'clock, in full sea rig, and with my chest.
>
> The change from the tight dress coat, silk cap and kid gloves of an undergraduate at Cambridge, to the loose duck trowsers, checked shirt and tarpaulin hat of a sailor, though somewhat of a transformation, was soon made, and I supposed that I should pass very well for a jack tar. But it is impossible to deceive the practiced eye in these matters; and while I supposed myself to be looking as salt as Neptune himself, I was, no doubt, known for a landsman by every one on board as soon as I hove in sight. ...
>
> In a short time every one was in motion, the sails loosed, the yards braced, and we began to heave up the anchor. I could take but little part in all these preparations. My little knowledge of a vessel was at fault. Unintelligible orders were so rapidly given and so immediately executed; there was such a hurrying about, and such an intermingling of strange cries and stranger actions, that I was completely bewildered. There is not so helpless and pitiable an object in the world as a landsman beginning a sailor's life.
>
> ~ Richard Henry Dana, *Two Years Before the Mast*, 1840/2001, pp. 6-8

ACNPs provide care to patients with complex, acute, and often life-threatening health problems. Hemodynamic instability, pulmonary compromise, and nosocomial infections are frequent concerns related to acutely ill patients. Many hospitalized patients have multisystem diseases, which can contribute to atypical presentations of symptoms. Acute complications of chronic illnesses can develop in response to therapeutic treatments for other conditions (e.g., an acute exacerbation of congestive heart failure after blood transfusion). Complexity of health problems and clinical judgment is compounded by therapeutic interventions or technologic modalities that often obscure important physical assessment findings (e.g., central nervous system depressants, intubation, mechanical ventilation). The risks associated with the physiologic instability of patients and the potential for developing life-threatening complications often require ACNPs to make clinical judgments rapidly in tense situations. Data can be simultaneously overwhelming and incomplete. These factors challenge the diagnostic reasoning process, potentially impeding hypotheses generation and evaluation, problem identification, and treatment decision-making. Yet ACNPs are tasked with the job to accurately diagnose and treat the health problems of their patients. ACNPs doubt their abilities to use what they know to care for patients safely and have a concern that they should know more than what they have been taught. This results in the lived experience of *being uncertain*. *Being uncertain* creates an experience of being "overwhelmed" as they continue to learn "from the ground level up" how to "attack" patient care management on top of learning to "master" the procedural skills required in their practice.

> I wondered at the expectations. I wondered at the other NPs who do it and do they think they're doctors and I wondered if I had the skills or the knowledge to do it. I wondered if I'd make a fool of myself. I had always given someone the information and just done what they told me to do. Well now I was going to be the teller and that's so much responsibility and it was just so scary thinking that one day maybe I would make a decision that would be harmful or wrong. It was just so very overwhelming [long pause]. Very scary.
>
> And for the longest time, I thought, "Oh my God." And I thought how can I go back and how am I going to be able to survive this, and am I going to be able to do the things required of me?"

Prior to becoming ACNPs, most ACNPs have been nursing within a traditional health care model in the acute care setting in which the physician is seen as "the captain of the medical ship" (Gordon, 2005, p. 10). The charted course regarding the daily medical plan of patient care is handed down in the form of orders that nurses are expected to carry out. In accepting the ACNP role, particularly as pioneers and within practices where they frequently work in isolation of other ACNPs, they now find themselves in the position of performing in this capacity (at least some of the time). However, they do so without a navigational chart or a dedicated guide familiar with the ACNP journey. This leaves ACNPs in the position which most pioneers find themselves: "thrilled and exhilarated" about the potential opportunities for autonomy and intellectual challenge, but also "shocked and overwhelmed with what [they] don't know," along with few institutional supports to assist them with integration into their new practices.

Being uncertain pervades the ACNPs' life during the time of *being adrift*. They are persistently made aware of *being uncertain* by the distressful thoughts and feelings rooted in their day-to-day consciousness as they engage in the new activities of their practice. Some ACNPs describe *being uncertain* as merely "unsettling;" however, most reveal "feeling terrified," "being scared," and "being frightened," feelings that are present to some degree, most, if not all, of the time, and then heightened each time they are required to perform something new.

Which Will It Be?

Making hard choices can be difficult
because choices throw off
menacing shadows
called consequences.

Running away from hard choices
because of self doubt
or fear of the menacing shadows
is misery.
~ J. C. Justice (2004c)

> It was very frightening at the beginning. And like I said, I have a lot of experience behind me and I probably shouldn't have felt the way I did. But I think because I am a very conscientious person I tended to be very fearful. And I never look like I'm afraid on the outside but on the inside it's utter turmoil. So I was very anxious, extremely anxious, in this position for quite some time.
>
> For my first two years of working, every time I had a call to come see something the one thing I used to do when I got woken out of bed was say, "Dear God help me make it through the night." Seriously! "Help me make the right decision." People are lying if they don't tell you they're scared for those first two years.

For many months, and most often two to three years, ACNPs live with the uncomfortable awareness that they can make a mistake that could cause a patient's death. Not knowing if the outcomes of their decision-making will be the right ones creates a disequilibrium born out of fear for the patient's safety. ACNPs are often preoccupied with these "horrible thoughts," or "terrible things you just can't imagine," particularly after they leave the clinical area and have quiet time to dwell with the daily course of events. Even after two years of experience, one ACNP described that at the end of each day she still lives with "a niggling doubt" that she may have missed something. Perhaps the writing of Faye Ferguson (1991) helps us to better understand the experience of *being uncertain*. "When faced with uncertainty… the emotions can easily hold sway, carrying one away with thoughts of disaster. During these moments or hours one feels trapped, captive to the terror of what might be possible" (p. 316). Alice too, in her *Adventures in Wonderland*, reminds us that thoughts of disaster envelope us when we are faced with uncertainty.

> She found a little bottle on the table and tied round the neck of the bottle was a paper label, with the words 'DRINK ME" beautifully printed on it in large letters. It was all very well to say 'Drink me,' but the wise little Alice was not going to do that in a hurry. 'No, I'll look first,' she said, 'and see whether it's marked "poison" or not'; for she had read several nice little stories about children who had got burnt, and eaten up by wild beasts, and other unpleasant things, all because they would not remember the simple rules their friends had taught them; such as, that a red-hot poker will burn you if you hold it too long; and that, if you cut your finger very deeply with a knife, it usually bleeds; and she had never forgotten that, if you drink much from a bottle marked 'poison,' it is almost certain to disagree with you, sooner or later. (Louis Carroll,1865/1971, p.13).

There is a gravity of being associated with *being uncertain* that seeks its expression in the form of "mental turmoil." Each decision feels like having narrowly escaped from causing a deadly outcome. "Treading water" and "barely keeping afloat," while trying to keep their "heads above water, trying not to kill anyone, and trying just to get comfortable"[15] creates an overall weariness and mental exhaustion resulting from a constant state of being "mentally on guard" and "second guessing." One ACNP described that for nearly three years she "paddled like crazy" to absorb as much academic knowledge as she could while attempting to make it have practical meaning in her decision-making with each new patient for whom she was responsible. Inability to sleep, along with "nightmares" every night or "dreaming all night long about their patients" are common due to the worry and doubt they experience regarding the accuracy of their decision-making.

> One of my fears is that I will write an order and it will be misread or incorrectly processed or something and then something harmful could happen. ...The first time I wrote an order I shook for probably a day. .... Again the mental turmoil is I spend a lot of my time after work more or less just going through my head the events of the day... But I always look at - What have I done? What have I ordered? Was there something better? Should I have done it differently? I pay particular attention to every medication that I order, because to me

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[15] Pool of Tears by Louis Carroll (1971) in *Alice's Adventures in Wonderland* (p. 20). Licensed under a Creative Commons License. Retrieved August 4, 2006 from http://www.mythfolklore.net/3034mythfolklore/reading/alice/images

> that's the ultimate mistake right there. And dealing with it? ...If you have any doubts about what you've ordered or what you've done, then you go back, you look at it, and you change it, or you look at it and you decide that it really is the right way and just leave it. So there have been a few times when I've actually gotten home and I've had to turn around and come back because I've second guessed myself. And it's been silly, but I've needed to do that in order to put my mind at ease.

This mental fatigue is compounded by the drain of energy required to hide the inner turmoil they frequently experience. In the following passage, an ACNP demonstrates the heaviness or gravity of *being uncertain*. This passage was delivered in a tone that invoked the arduousness of *being adrift*, that is, the difficult, grueling, demanding, and tiring nature of "not knowing" and thus *being uncertain*.

> I was very tired. I was so tired from making decisions. I just remember thinking I don't want to make another decision today about anything. And it was such hard work, such hard work to do this. And you know - Lasix q6, q8, q 12? I don't know. Once a day? You've got to think about this, this, this, and this. You need to look at a weight gain, and fluids, fluid balance, urine output. And it was just so tiring because there was so much to think about. I can remember going home after these twenty-four-hour-call-shifts, and not physically tired from being up, but just mentally tired from having to make these decisions.

"Do I have the ability to make the decisions? How should I approach this problem? How do I solve it?" "Do I know what to do?" "What do others want me to know and do versus what do I need to know and do?" Questions, rather than answers, dominate in the ACNPs' experience of *being adrift* and contribute to *being uncertain*. As these passages and questions begin to reveal, *being uncertain* is rooted in concerns and perceptions about "not knowing." *Being uncertain* is about the tension between what ACNPs perceive they know and what they should know but do not. *Being uncertain* is about "not knowing" the full depth and breadth of knowledge and skills necessary to make the clinical decisions required of them in their practice. This results in "not knowing" how to anticipate or predict what will happen and how to attempt to control the outcome. *Being uncertain* is about "not knowing" if they will make accurate clinical management decisions or whether they will ever be capable of making those decisions. *Being uncertain* is about "not knowing" how to carry the weight of responsibility that results from making those clinical decisions. *Being uncertain* is about "not knowing" the expectations required of them, the milestones to be met, to whom they can turn, and whether others will be there to support them.

> This road differs from those on dry land in three ways. The one on land is firm, this unstable. The one on land is quiet, this moving. The one on land is marked, the one on the sea, unknown. ~ Martin Cortes, Breve Compendio de la Esfera[16]

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[16] Cited in Pérez-Reverte, A. (2001). *The nautical chart.* (M. S. Peden, Trans.). New York: Harcourt.

For many ACNPs, *being uncertain* is like "paddling in a swamp." Although on the surface all may look serene and calm, many are "blindly paddling, paddling, paddling" as fast as they can in what at times feels like a quagmire that is "dragging them down," all the while *being uncertain* as to what lingers in the depths below the surface. They realize that they are being pulled along by a current stronger than they had anticipated, and suddenly the river narrows, the undergrowth on the banks seems too vibrant, and they hear the sinister roar of rapids. Their heart quickens with dread, even as they feel a thrill of anticipation (Gray, 2006).

Embedded but concealed in "not knowing" is the implication of the word *yet*. There is a sense that answers to all these questions will be revealed in the future; "time will tell." *Being uncertain* is not only about how the ACNP feels in the moment but it holds an orientation to the future. In the following passage, an ACNP describes the fear she lives with resulting from *being uncertain* about the outcome of her clinical decision-making, not only for her patients, but also the NPs' professional reputation. There is a sense of "not knowing" whether she will be able to protect the NP's newly developing reputation, which is directly connected to being viewed by others as competent, or conversely, incompetent.

> I mean you're always afraid that you're going to screw up and be caught screwing up. And there is this onus on new practitioners because in this province and in this city nurse practitioners are new, like three years is about it where I work. So there's always this onus that you don't want it to be, "Oh, those nurse practitioners!" You don't want that ever to be heard. You want to provide excellence all the time. Of course that's not realistic though. So I guess that's my fear too, because you work so hard to gain credibility and gain trust and be taken seriously, that you don't want to do something stupid, because one little thing can undo so much hard work.

Buehler (1987) similarly reported that the burden of reputation protection is heavy for NPs. NPs must not only protect their own professional reputation but also the reputation of physicians associated with them. Ultimately, they believe that the reputation of the whole NP movement is in their hands.

> I think the pressure not to make mistakes is much more for us than physicians. If we make a mistake there a lot of people jeopardized besides you and the patient and our MD back-up. The whole program, you know, the whole movement can be hurt. I think that's why most nurse practitioners take so much time with patients. The just don't want to miss anything. (Buehler, p. 43)

For these reasons, some degree of risk-taking is required on the part of ACNPs while they wait for the answers to all these questions. In the meantime, *being uncertain*, which results from not *yet* knowing, leads to self-doubt and feelings of loss of control, an ironic position, given the purpose for departure on the journey is to gain more control in their practice.

Living with the overwhelming sense of uncertainty about their abilities to engage in a new level of decision-making is linked with "not knowing how to think like a physician." Yet from the time ACNPs walk into the clinical setting with the ACNP title, they are required to make numerous and varied daily decisions. These decisions fill them with uncertainty because they realize that they lack the depth and breadth of experiential knowledge and critical thinking or decision-making skills necessary to care for the patients safely.

> It was hard at first. I remember doing an admission for almost the first time and it's like – nobody showed me how to do this. Am I doing this right? Am I writing this right? It was scary.
>
> Well my first day on the job someone said to me, "I think this person needs a blood transfusion, can you write it?" I'm like, "No. No. I'm not gonna do that." …"No I'm not ordering you that blood transfusion. Absolutely not!" So certainly it wasn't right away that I felt like an NP, even though, I was in the job and using the title and stuff.
>
> I didn't like the responsibility of decision-making at first. I would get pages saying their heart rate's irregular or something and I would think, "Good God, call someone who knows. I'm not a cardiology NP in the arrhythmia clinic. I'm a nephrology NP who's had some paediatric background. I didn't much appreciate being presented with that kind of problem. I didn't anticipate that; I didn't see that coming. That's one thing that caught me completely by surprise. "What do you mean I have to medically look after the whole patient and not just dialysis?"
>
> Overwhelming, scary, a lack of confidence in yourself, nervous, anxiety, excited, all of those kinds of feelings you get when you're dealing with the unexpected and you know that anything can happen at any time and you have to be prepared for it but you don't have all the knowledge you need. Because when I first started I had a lot of on-the-job learning to do. I really did, even though I went through the NP program and it was great but there were a lot of knowledge gaps. It's very generic, which I guess is what it has to be, but when you take that back to your own clinical environment there are a lot of things that I needed to learn, things like how to manage a diabetic patient for instance; or though we had microbiology and that kind of stuff and prescription of antibiotics, when you actually get into the clinical area and you're dealing with infections and organisms and sensitivities and antibiotics and this whole thing with resistance and that kind of stuff, and there's a huge learning curve to that. And then more critical care stuff, stuff like gut ischemia and esophageal varices and bleeding and ulcers and peritonitis and pancreatitis and adrenal insufficiency and it just goes on and on and stuff that I didn't know and I'm like, "Oh my God, like here I am in this critical care environment and look at all this stuff and here it is, and I'm like ahhh!! And what if I compromise all these vulnerable patients you know?"

ACNPs understand that the "NP part" of their job requires a "sort of 'medical' apprenticeship" in the first several years in order to learn the "clinical management" of the patients in their specialty population. But despite whether it is what they expected or wanted, for a number of months ACNPs "suddenly" find themselves unsure of what to do, what they know and don't know because, as nurses, they have "not been trained to think the way doctors do. It's a whole different way of thinking and it's really hard." Although they have a "sense" that there should be more to the ACNP role than being a physician replacement, "the truth be told that is exactly what [they] do" during the "apprenticeship" period. ACNPs frequently mention that they function from a medical model instead of a nursing model of care but, in hindsight, realize this is necessary at the beginning, an understanding that has also been noted in the primary care NP literature (Kelly & Mathews, 2001).

One of the characteristics of belonging to a homogeneous community of practice is the development of a shared culture. As noted by Wenger (1998), the culture of a community of practice includes routines, words, tools, ways of doing things, stories, gestures, symbols, actions, or concepts that the community has produced or adopted in the course of its existence, and which have become part of its practice. The culture includes the discourse by which members create meaningful statements about the world, as well as the styles by which they express their forms of membership and their identities as members (p. 83). However, as pioneers in their practice, as well as frequently working in isolation of other ACNPs, there is no ACNP community of practice with whom most ACNPs can experience their world and find meaningful engagement related to being ACNPs. Nor has the global Canadian ACNP community of practice yet been able to establish itself a historically recognizable culture such that "everybody knows what ACNPs are supposed to be doing." In other words, other communities, such as nursing, medicine, pharmacy, and society, do not yet know, appreciate, predict and therefore subsequently trust, who they are and what they can do. Each ACNP is therefore required "to prove themselves" as being "someone legitimate in providing care," because "until [others] understand the ANCP role", "they will always be compared to other physicians, other residents."

> Because at first they really have very little insight into what we can do, what training we've had and they tend to treat NPs on a very individual basis like, "oh yeah, I know you're okay, but she'll have to prove herself to me," whereas if they came up to them as a medical resident and I'm X year, then they have a certain conception of what that person should be capable of doing, what they have been exposed to or not exposed to.

Initially then, the negotiation of meaning for ACNPs is created primarily in their social relationships with physicians, on whom they are reliant for the delivery of safe practice in their work setting, along with the nurses with whom they work. Yet, once they enter their clinical practice, ACNPs find themselves on the fringes of medicine's

community of practice of which they have limited knowledge and know how. At the same time they feel they no longer live within the community of nursing that they know.
This situation augments their experience of *being uncertain*. Consequently, in order to belong to the communities of practice of which they are apart, they must engage in the practices, routines, language, and conventions of those other communities. In other words, ACNPs need to do whatever it takes to make mutual engagement possible. For ACNPs, this means they must demonstrate they know how to "think" like the members of that community. Yet, not knowing "how to think like a physician" is partially at the root of *being uncertain*, because "not knowing" how to think like a physician is to some extent a measure of not yet knowing enough of the language of a physician. This is not dissimilar to Alice's Adventures in Wonderland: "…'but then I wonder what Latitude or Longitude I've got to?' (Alice had not the slightest idea what Latitude was, or Longitude either, but she thought they were nice grand words to say.)" (Carroll, 1865/1971, p. 11). However, ACNPs simply do not yet have the depth and breadth of terminology that is associated with advanced anatomical, physiological, pathophysiological, and pharmacological knowledge. "Not knowing" the language results in not understanding others, as well as not being understood by others. Mutual engagement is impeded and *being uncertain* intensifies. Perhaps not yet knowing how to "think" in the physician's language, or at least without *thinking about* it, results in ACNPs feeling as if they are foreigners or strangers in a strange land.

> "Would it be of any use, now,' thought Alice, 'to speak to this mouse? Everything is so out-of-the-way down here, that I should think very likely it can talk: at any rate, there's no harm in trying.' So she began: 'O Mouse, do you know the way out of this pool? I am very tired of swimming about here O Mouse!' (Alice thought this must be the right way of speaking to a mouse: she had never done such a thing before, but she remembered having seen, in her brother's Latin Grammar, 'A mouse – of a mouse – to a mouse – a mouse – O mouse!'). The mouse looked at her rather inquisitively, and seemed to her to wink with one of its little eyes, but it said nothing. (Lewis Carroll, p. 21)

Being uncertain is made all the more clear in the following passage. Imagine the ACNP's tone changing from one of gritty command and outspokenness to something more reminiscence of a subdued and whimpering child. Understanding how distressful *being uncertain* can be and the tendency for uncertainty to diminish a person in his/her own eyes despite the previous level of confidence and competence is revealed in the manner in which this ACNP expresses the experience of *not knowing*. "Think thou how that this is not our home in this world, in which we are strangers, one not knowing another's speech and language" (The Diary of Samuel Ward, entry for May 13, 1595 as cited by Wu, 1991).

> Well it is hard because you don't know if you're on the same page. And when I think of describing an x-ray to somebody - because even to this day you can say, "well, he has that kind of blah, blah, blah" - but they don't necessarily use the same words that can mean the same thing. And x-rays are quite hard, because there's something there and they want to know what it is. And well, I think it's this because I see a shadow, and you don't call it lucency or darkness, or it's, fluffy [laughing]. And I know them better now, but at the time, you know, near the heart, near the thymus or the hilum. You know, they ask you so you end up saying, "Well I'm not sure that I see that or not. I can't tell you."

At the same time, *being uncertain* as to how to think like a physician is also concerned with not yet knowing how to speak like a physician. In fact, learning to "speak the physician's language" is what makes mutual engagement with the medical discipline possible. Physician's speech is associated with the way in which the text is formatted and presented; it is the way in which information is edited so that how the information is orally re-presented to the medical audience is in a manner that is accepted and appreciated by them.

> The type of information that physicians want to hear is not the same as what nurses want to hear. ...I remember when I was a novice NP, I would report everything [voice rises in emphasis] in tremendous [voice rises] detail and the comments were frequently, "this is very thorough but I don't need this. As a nurse I can understand that you would want to know these things, but from a physician's perspective this is what I'm interested in." And the difference was learning that when you're talking to physicians to communicate what they [emphasized] want to know, and in that way you communicate that you understand what's important to them.

Being uncertain with regards to their use of medical language and speech becomes critical in relation to such actions and artifacts as medical rounds, the order sheet, physician notes, or discharge summary records. Although nurses are familiar with and have shared points of reference with regards to these customs, they do not impose the same meaning when viewed from the role of a bedside nurse as when viewed from the new perspective of being an ACNP. The particular nature of nursing's understanding of these elements of practice lies in the rules and regulations or structures applied to these artifacts and conventions, which are determined as much from within nursing as from without. Gadamer's (1960/1989) writings on the concepts of both language and play help us to understand that nurses learn through their community of practice the task(s) to enact in their assigned (and chosen) role, the space in which to play it out, the type of comportment needed, the choreography between players, and the discourse needed to enact the role in order that they can represent themselves correctly. In other words, traditions have been formed and the concept of their practice and who they are as nurses is understood by self and others through the resulting discourse in relation to each of these conventions. However, these same linguistic and nonlinguistic elements take on new interpretations when used to new effects by the ACNP and viewed from a new trajectory. As a point of illustration, ACNPs describe medical rounds as the quintessence of being placed front and centre without having the requisite skills to stand upright without feeling exposed. In this once familiar but now unfamiliar surrounding, the ACNPs constantly experience this sense of *being uncertain*, of not knowing what to expect, of not knowing how to articulate the limited knowledge they have, and of not knowing what level of knowledge is expected of them. It is during medical rounds that they realize that their lack of knowledge and/or inability to articulate what they do know in a meaningful way can no longer go entirely unnoticed by others. They no longer have the protection of being a spectator but are required to be active performers even without the requisite tools. Being uncertain in this situation means feeling "on the front line", of "being exposed", or "of being unprotected."

> It was like having to go into an exam every morning and have no idea what the exam would be on. Furthermore, it's an exam in front of ten other people and they'll all know what you know and don't know, and that was very stressful. I remember using those exact words with my husband. It's like writing an exam every day and you don't know what it's about, what the subject is. Very, very stressful. And because you would get quizzed on rounds, everyone's watching and listening. ...And we are treated very much like a resident and so then you're asked why this and why that and what do you know about this and what do you know about that and tell me about this or that. So I mean I haven't been to medical school; half that stuff I've never heard of, and all of a sudden I'm expected to know it. It's quite daunting.
>
> I guess talking through on rounds, being responsible for pulling it all together in a summary and valuing everyone else's input and not repeating it, but being the center of attention as you're grasping through - okay let's make a plan for the day and doing the summary. That was a big transition. And the questioning and the answering, where this was your patient - well it's everyone's patient - but you're ultimately responsible for it. And questions that the physician would put you on the spot.

Medical rounds take on new meaning because it is here that ACNPs are required to make evident to the team, through the use of medical language and speech, their ability to put all the pieces of the puzzle together in a way that demonstrates a grasp of the patients' medical problems and plan of care. In front of everyone, they are required to think out loud in order to prove their ability to analyze and synthesize information and demonstrate their critical thinking skills, when most of their experience as nurses has taught them to be more or less invisible. ACNPs appreciate from their years of working in acute care teaching institutions that medical rounds are part of medicine's initiation process. They are what Turner (1969) would refer to as a *rite de passage*, part of the ritual process created by the community of practice to assist in the transition from one place, state, and social position into another. It is in this milieu that others, particularly the physicians, actually judge the ACNPs' performance against their definition of what constitutes competent NP performance, a definition that mimics their own particularistic philosophy of medical practice. ACNPs understand that it is in their ability to articulate their understanding and summarize the plan of care that members of the team will develop a respect for their abilities, the ACNP role in general, and for each of them as individuals. *Being uncertain*, however, causes ACNPs to feel an overwhelming discomfort with this responsibility and fear of being exposed as imposters or somehow "not legitimate." *Being uncertain* in this milieu brings about a strong awareness that "everyone is judging you." ACNPs feel that perhaps others are seeing them for the very first time in terms of what they are lacking, not for the competent or expert nurses they had been previously. As importantly, what really makes *being uncertain* so discomforting is the constant awareness of self, particularly "one's deficiencies" that this visibility and awareness of uncertainty invokes.

Similarly, ACNPs are required to engage in medical discourse using the written format within medical artifacts. However, not knowing how to write medical orders, medical progress notes, and discharge summaries adds to the ACNPs feelings of uncertainty, which is further intensified by the uncertainty that comes with crossing boundaries that have been previously forbidden to them as nurses.

> So having to learn the language and really not being given any course on how to write an order per say, and there is a format on how to write orders, what needs to be included; there is a process around that. And that isn't part of the orientation or internship or whatever it is called. And there needs to be more value put on it because the significance of that is huge, and it was an area where I didn't have any experience with it.
>
> Initially my histories were like two pages long, and, "No, no, no. You've got to condense, condense, condense." ...And you have to learn to write the notes in the language they speak and in way that they're going to want to read them.
>
> But I remember one admission I was doing on the evening by myself and I wrote this one up and the doctor came in and he started correcting it, adding stuff to it, and I felt so bad that I hadn't done this right, and oh man. And I didn't write down that the testes were descended. I might have palpated them, but I didn't put that down. And that sticks in my mind. But then the next time I was writing, I'm constantly thinking, 'Well what did I miss?'
>
> It's not easy to flip over to writing on the physician's order sheet and directing your colleagues in terms of giving them orders.

Being uncertain also emerges when ACNPs are unsure of how to interpret information in a new and different way, which culminates in the generation of a possible problem list, a differential diagnosis, and treatment plan. "Not knowing" how to make a diagnosis and *being uncertain* as to whether it is the right one is frightening and sometimes even paralyzing for ACNPs. Additionally, their uncertainty is only accentuated when they have limited knowledge and experience within their specialty area, precluding them from "identifying patterns." As noted by one ACNP, "a leap of faith" by self and others is required for ACNPs to take on the risk of making decisions when one feels so uncertain. It is easier for ACNPs to place their faith in the gods than it is to have confidence in their own abilities and skills. ACNPs immediately realize that knowing how to make a differential diagnosis is not something learned in nursing and it is a concept that can be quite difficult to grasp. Learning to think of all the possibilities, particularly when one has limited knowledge of the possibilities, while at the same time being able to prioritize one's plan around the most likely possibility when scanty information is available, is like climbing the main mast of a ship without a safety line. *Being uncertain* is also compounded by not knowing the routines and what the various doctors in their practice want and will accept. In other words, they do not know how each particular physician thinks. Interestingly, even when they are able to make the diagnosis accurately, the actual verbalization or writing of the diagnosis can be overwhelming in and of itself, as it too is a boundary not previously crossed by nurses.

> Making the diagnosis is difficult at times. I personally struggle with it unless it's fairly obvious. I never have done very well pulling differential diagnoses out of the hat and I think that's where I need to do a bit more work; but diagnosing is difficult I find. Remember that we get a lot of our patients from Emergency and they've got the diagnosis down in front of us. So I look at the diagnosis and I think, "Um, why did he choose that? Well alright, belly pain. Oh my God, there's probably a gazillion things that cause belly pain." So I find that once I've got the diagnosis in front of me, sure I can see it, but if have to see somebody cold turkey that's where I struggle a bit. We can diagnose congestive heart failure easily; if you come in with high sugars, well you're obviously in a diabetic state. It's the not so clear cases – I'm thinking, well some guy's diagnosed Dengue Fever, where did that come from? Why did he diagnose that? Well, I'm not familiar with the pattern of that, that doesn't even pop into my mind. And then again, I think, "Well goodness, should I know that?" And then this self-doubt thing overcomes me: "Well my God I wouldn't have written down Dengue Fever." So that's what goes through my mind.

> I guess one of the things that stunned me the most and took me a long time to get over was being able to actually write that the man had a nose bleed rather than saying the man had blood coming from his nose; so that as an NP I can actually diagnose that nose bleed. So the hardest thing to get my mind around was now I could suddenly do these things that you were always told you couldn't.

Being uncertain also concerns not knowing what is considered within one's scope of practice. If we don't know what we don't know, it is impossible to identify with any degree of certainty what we are supposed to know versus what we don't need to know. Buehler (1987) wrote that "educators and physicians repeatedly point out that the single most important attribute of a NP is [their] 'knowing and practicing within [their] limits'. The clinical judgments they make determine how others evaluate their compliance with this norm" (p. 50). Yet, the question - what is beyond my scope of practice? - reveals the ACNPs' struggle to determine the set of expectations about the level of knowledge and skill that is required within each of their practices. For ACNPs (except in the field of neonatal nursing), *being uncertain* is accentuated because there is not yet an aggregate of ACNPs who are performing the same role within the same context. There has been no historical determination of what it is they do, how it is they are to do it, and the level to which they are to perform it. In other words, a community of practice who, as a matter of routine, through seeing each other every day, talking with each other all the time, exchanging information and opinions, and thus directly influencing one's understanding, is not readily available to these pioneers to diminish or relieve their uncertainty. ACNPs are uncertain about their abilities not merely through the normal course of being a novice but also because the expectations of competency have yet to be determined. The irony associated with this aspect of *being uncertain* is that ACNPs cannot discover the independence within their practice they are searching for until they know their limitations, limitations that are defined by their scope of practice.

The passages presented thus far suggest that *being uncertain* is inextricably bound to worry about the various aspects of clinical management. For ACNPs, being "a worrier" or "fretting" is a common response to *being uncertain*.

> Well I am a bit of a worrier and of course the nurse in me always wants to do the good, the best job. And I don't like to make mistakes and I'm a bit of a fretter. So it's taken me a bit of time to become comfortable with what I'm doing. I believe I've got the knowledge to do it but it's the confidence and not to second guess myself.
>
> I think you really don't even start to feel like an ANCP until you've faced what you dread most. Probably for me it was after my first code. I think you really have to get through that because otherwise you dread it and worry about it until it happens and it's like the worst thing you can imagine happening and so it just looms big.

The word *worry* is a violent verb that can be traced back to the eighth-century Old English verb, *wyrgan*, which is akin to the Old German word, *würgen*, and the Old Dutch, *worgen*, all meaning to strangle or constrict (Barnhart, 1988). This idea of a physical constriction is involved in the origin of two other words of similar meaning. Anxiety, first appearing in English in the sixteenth-century, was formed directly from the Latin noun *anxietas*, a derivative of the adjective *anxius* 'anxious', which derived from the verb *angere* 'to strangle' (Barnhart). The word *straiten*, also a sixteenth-century addition to our language, has a similar semantic history and is based on the early French adjective *estreit*, which derived from the Latin word *strictus*, the past participle of the verb *stringere* 'to bind tight.' The word *straiten* is related then to strain and the notion of stress. The word strain came into Middle English as *streinen*, also a derivative of the Latin verb *stringere* (Barnhart). Just as dogs and wolves worry their prey by seizing them by the throat and pulling at them until dead, concerns and fears work away unrelentingly in our imaginations to make us feel anxious and strained. The Oxford English Dictionary (Trumble & Stevenson, 2002) confirms this sense by defining worry as "a state of mental unease or anxiety arising from one's cares or responsibilities, uncertainty about the future, and fear of failure."

> Worry affects circulation, the heart and the glands, the whole nervous system, and profoundly affects the heart. I have never known a man who died from overwork, but many who died from doubt. (Dr. Charles Mayo, MacMilllan Dictionary of Quotations, 2000)

Worrying arises from ACNPs *being uncertain* as to whether they will be able to independently reproduce the decision-making sequence without missing critical steps. Worrying arises from *being uncertain* if they have gathered all the information necessary to make an accurate diagnosis and treatment plan. Worrying arises from *being uncertain* as to whether they can successfully repeat what it is they do, such as performing a psychomotor skill under pressure or in a different circumstance. ACNPs worry about whether they will succeed at their endeavors and worry that they will harm the patient if they fail.

> You're terrified a lot of the time. Like I mean, doing the intubations in the case room when there's a big neck and it's like [sucks in air and gulps] because when you're first doing them you're not sure that you can repeat it, even though you've done the skills; like can you do it under this pressure and can you do that?

Worrying is associated with the desire to do what is right and what is good for the patients who are entrusted to their care. They are worried about "missing the boat," being wrong, and making a mistake that will further compromise and harm the patient. When asked what it was initially like to take on the responsibility of caring for the patient as an ACNP, it became evident that living with *being uncertain* is a key component to the worry and fear they experience. It bears reinforcing that many ACNPs come to this role as nursing experts. They carry a mature and practiced understanding of what it means for the patient and family to provide, or failure to provide, the "right" treatment. "Knowing how" to provide the "right" care is essential to clinical judgment and ethical comportment and an inability to do so causes them enormous worry and fear. Central to their being in *being adrift* is a concern for being able, or contrarily, being unable, to respond to the patient's physiological needs, protecting them in their physical vulnerability, and helping them to feel safe in their hands. The heavy burden or unrelenting strain that their one mistake "might just tip them over the edge," makes them worry "every minute." Typically, there is a sense of hyper-alertness and hyper-responsibility and ACNPs purposely engage in multiple mechanisms in order to cope with it. Unlike Benner's (1984) research findings, this sense of hyper-responsibility is present in the initial part of the ACNPs' journey, not at the competent stage of the novice to expert continuum. This may be related to the fact that ACNPs know what it means to be, at minimum, competent nurses and therefore understand the tensions and the competing risks involved in managing any clinical situation. Additionally, as experienced nurses, they have long lost their naivety about the absolute trustworthiness of the environment and legitimacy of co-worker's knowledge. Naivety normally allows the beginning learner to absorb information as fact and truth, and for this reason they experience a sense of certainty about the outcomes of their actions, along with a sense of excitement about learning. For many ACNPs, this sense of "fun" and exhilaration is not experienced until later in their journey.

ACNPs readily acknowledge that as experienced bedside nurses they believed they often had the experiential knowledge to know what treatment was required in the clinical situation, although they did not possess the authority or control to act upon it. Indeed, this was a strong source of frustration for them as nurses and as such becomes one impetus to begin the journey to becoming an ACNP. Yet ironically, when permission is finally granted for them to act upon their knowledge and skill, they immediately realize that being able to do what needs to be done involves much more than being permitted to use advanced theoretical and experiential knowledge.

> Like I said, I've been a nurse for a long time. Nurses always tend to hang back a little bit; we're pretty good talkers - "This is what should be done." But when you're in that role and you can write the orders to do something, well there's that responsibility issue that you're responsible for that order, so you'd better not be making a mistake; you'd better think it through. And I take that very seriously.
>
> I think people would give the example, in critical care as a bedside nurse, "Oh I think this person needs Lasix," and you can pretty much determine when and how much. But when you're the person actually writing the order to give the Lasix you're gonna be going through a few different things in your head than the nurse saying, "Gee, what do you think about..." When you actually have that accountability or decision-making or responsibility for the decisions, it becomes much different than just suggesting, "What do you think about this drug or that type of thing?" Yeah, it's different. And maybe it's not so much assessment but it's the responsibility. ...I mean it's much more. I mean you're the one ordering the drug. I mean what if there was a contraindication somewhere that you didn't know about? What if you gave the wrong dose? What if you ordered two grams of Vanco instead of one gram? What happens then? You know, I think it's that accountability. It's that responsibility. Did I think about this and did I think about that? You check the allergies about four times and then you come back to the bedside again just to check, "I better make sure they're not allergic to that." You know, calling from home and saying, "Can you just check to make sure

> that I ordered this preparation of iron and not the one that they're allergic to?" That type of thing. Much different, more responsibility than I can recall as a staff nurse.
>
> In one sense making a medical diagnosis and writing orders is not too much different. It's just an extension of what nurses have always done, sort of integrating bits of medicine into their practice. But it is different in that it's more focused and I think, although I'm loath to say it's a more responsible role, because the results of your assessment are going to drive what happens to the patient. So if you screw it up the patient's gonna suffer. And although you always have a fall back position it's basically only there if you request it. They don't double check your work. So the expectation is you get it right. So that's a different level of responsibility. It's a different level of attention to detail.

"Be careful what you ask for, you just might get it" is an expression that carries the full weight of its meaning in this situation. With the granting of the authority to diagnose, prescribe, and treat in other ways previously denied them, comes the responsibility of carrying the tremendous burden of uncertainty as to whether one will harm those for whom they have been entrusted to care for safely. Not only must the ACNP acknowledge that they "may" and "can" do what needs to be done for the patient, they must also acknowledge and accept responsibility for it. Paradoxically, *being uncertain* means that they now experience a lack of self-confidence and hesitation as a consequence of being faced with the increased responsibility and accountability for the patient's health (Hickey, Ouimette, & Venegoini, 1996).

Why is the ACNP's relationship with responsibility so personal and intensified as compared to that of the bedside nurse? Is it possible that coming from a place of having been an expert nurse with a high degree of knowledge and skill embedded in a strong sense of moral responsibility only serves to heighten the tension and apprehension around issues of responsibility and their consequences? The old adage of what you don't know won't hurt you does not apply to the ACNPs, since most nurses come to the ACNP position as experiential experts in nursing knowledge within their clinical specialty. They have long lost their naivety about health care and have seen the negative outcomes that can happen as a result of errors in clinical judgment. In addition, ACNPs are embedded in a strong nursing history that emphasizes moral and ethical standards of a duty to practice within an ideology of "conscientiousness" and a "high ethical and professional standard" of care (Nightingale, 1859/1992, p. 3) for those with whom one is engaged in a caring relationship. It is an ideology that emphasizes caring for those with illness rather than curing illness. Therefore, ACNPs experience an internal angst that arises from a clash of expectations between their own values and expectations of self and the "what if" consequences of those expectations when they engage in acts associated with curing illness.

ACNPs have not been educated within an ideology that facilitates the objectification of the patient in the form of a disease entity or bodily part that requires repair or "cure." Rather, ACNPs have been indoctrinated in a caring philosophy that requests they respond to the call of the vulnerable who need their care in a manner that demands they act "responsively and responsibly" (van Manen, 1991, p. 97). As a result, they have difficulty distancing themselves from the vulnerability they see within the nurse-patient relationship. Yet ACNPs now find themselves engaging in acts that necessitate risk-taking behaviors that seem to be in direct opposition to this very call. To take risks, which is what is demanded in situations of informational ambiguity as it is applied to medicine (Haas & Shaffir, 1987), is a characteristic that neither comes naturally, nor has been learned through previous training as nurses. In fact, as one ACNP noted about the "mind set" associated with risk taking and its application to clinical decision-making, "I think that's a difference between nursing and medicine; medicine is sort of "the buck stops here," where for a lot of nursing practice it's "call the physician." Subsequently, as an element of *being uncertain*, ACNPs worry and experience a sense of premature guilt for what might occur if the "what if" situations should come to pass.

"Being-guilty," Heidegger (1927/1962) told us, "has the signification of 'being responsible for' ["schuld sein an"] – that is, being the cause or author of something, or even 'being the occasion' for something" [p. 327). He also wrote that "'Being-guilty' as '*having debts*' ["*Schulden haben*"] is a way of Being with Others in the field of concern, as in providing something or bringing it along" (p. 327). These two ways of "Being-guilty" when experienced in combination define a kind of behavior Heidegger called "making oneself responsible" (p. 327), which he argued results from Dasein "having the responsibility for the Other's becoming endangered" (p. 327). "Being-guilty" in this sense results from "the breach of a 'moral requirement'" (p. 328), even if that breach is only an anticipated one.

Emmanuel Levinas (1989/1996), one of the most significant ethical philosophers of the twentieth century, expanded the domain of phenomenology beyond the projects initiated by Heidegger. It is in his writings of the phenomenology of the face that we can perhaps better understand this call to responsibility and the resulting turmoil ACNPs experience in *being uncertain*. For Levinas, the face is a mode in which the vulnerable Other is revealed. As this vulnerability is revealed, we recognize that we have been summoned to responsibility. "The Other becomes my neighbour precisely through the way the face summons me, calls for me, begs for me, and in so doing recalls my responsibility, and calls me into question" (p. 131). Levinas acknowledged that in this ethical imperative, responsibility to Other "goes beyond what I may or may not have done to the Other or whatever acts I may or may not have committed" (p. 131). ACNPs experience intense feelings of vulnerability embedded in feelings of future-oriented culpability concerning their clinical decision-making when they realize that they could potentially inflict harm upon the Other. The ACNPs' emotional and mental unease experienced in *being uncertain* reveals their moral imperative and vigilance to the face of Other and thus the nature of their practice. A newer and deeper understanding is gained of what it means when we speak of the "call to duty."

As most ACNPs are quick to point out, learning to write physician orders and to write in the physician order sheet fills them with trepidation. They come face-to-face with the weight of the responsibility they carry in the act of writing. On one level the writing of the medical orders on the doctor's order sheet, the writing of the medical progress notes in the physician's section, and the writing of the discharge note, along with their signature, are clear examples of the operation of micropower. Yet at the same time, this writing carries both a heavy symbolism and strong structural connections to explicit, hierarchical, power structures.

> We write orders all the time as nurses but we take verbal orders and we just transcribe them onto the thing and so you go okay fine. The first time I wrote an order, I have to say, it was somewhat exhilarating. It's like - Wow! Geez I'm doing this; this is kind of cool. Alright, what will I do? Wow! And once you get over that, the responsibility part of your brain kicks in and you think, "Yes I'm doing this and this is really a lot of fun and isn't this cool, nurses are writing orders," but again you need to think through your orders, and think through your decisions as to why you are ordering something, and what you're going to do with that information once you've ordered it. So it's fun to order all of these things but now what? So again it was very exciting, it still is rather exciting to have this, I guess, this little power that we have, but again there's a lot of responsibly with that, which again, I take quite seriously when I'm writing those orders.

However, at another level, the writing of the orders and the scribing of one's thought processes in the progress notes is about the ACNPs' willingness to accept responsibility for setting into motion a series of cause-effect activities, while simultaneously appreciating the enormity of those actions. As one ACNP metaphorically pointed out, "Always in the back of my mind is that the pen is the mightiest thing. You know, you must always be very careful with what you're writing because with a pen stroke, you could harm someone." The writing of an order and the use of the pen, once a taken-for-granted activity with a taken-for-granted tool, now takes on new significance in the ACNP role; pen put to paper has become a potential weapon and these nurses as ACNPs wield the instrument of potential harm, even destruction.

> I guess the biggest adjustment...was the writing of the orders on the order sheet. It was a real funny feeling...that physician territory of physician order sheet and a nurse writing on the physician order sheet. It seems so silly. But anyway, I mean...it seems so legal and liable and it was interesting. And you know you didn't want to make an error because it was in copies and when you see it in the court of law years down the road, and you recognize your writing on that physician sheet, you realize just how significant it is. So having to learn the language and really not being given any courses on how to write an order per say. ... There is a format on how to write orders, what needs to be included, a process around that. And that wasn't part of the initial orientation or internship. ...and you ask the physician, "Well how do you write this order?" And something so trivial, so secretarial, as writing the orders or dictating the orders, there needed to be more value put on it because the significance of that was huge.

This power of the pen has also been described in Richard Peschel's (1986) recalling of a haunting incident from his medical residency in his story "The Ritual and the Death Certificate." This story appears in a remarkable book entitled, *When a Doctor Hates a Patient and Other Chapters in a Young Physician's Life*. In this story, Peschel describes the first time he had to pronounce a patient dead. Having held the stethoscope to the patient's chest listening for some sounds of breathing and a heartbeat, and having "stood around for a while so it would appear that [he] had spent a respectable amount of time determining that the patient was dead," he felt "somehow disappointed" in the whole process. In other words, he had found there was "little reflection about a human life having just ended." However, when he went to complete the death certificate, and was instructed that he must use "the Brady pen" - Brady being the name of the morgue - he was suddenly confronted with the significance of the "death pen." The pen symbolized not only the solemnity and sanctity of the ritual, but also the gravity of the responsibility he carried. The pen gave the event meaning that no other activity in that entire situation had the ability to do.

Heidegger's (1927/1962) analysis of modes of engagement helps us to understand that prior to taking on the ACNP role, when nurses use their pen and the physician order sheet, they have no need for focal awareness of themselves and these tools. The skills and practices they bring to the activity are so familiar to them that they are simply unaware of their existence. In this ready-to-hand mode of activity, the nurses' actions and their situations fit each other. However, when they become ACNPs, they encounter the pen and order sheet in a way that brings about a state of *dis*-ease and this *dis*-ease becomes salient. In the use of the pen to write prescriptions and treatment orders, it is revealed that there is no longer a tailor-fit relationship between their actions and their situation. As a result of this state of *dis*-ease, ACNPs have the opportunity to “step back” and reflect, detaching themselves from the ongoing practical involvement in the project of writing orders and progress notes to better understand the significance of what it is they do when engaged in these activities. The resulting stepping back from "I" and the *re*-cognition of “I” in this situation creates not only self-reflection, but also self-conflict. What is the meaning of all this? Who am I? Am I alienated from myself as a nurse and from nursing as part of my world by engaging in these acts of writing orders, or making these types of clinical decisions? But perhaps, as Heidegger argued of the experience of anxiety, ACNPs are uncomfortable with *every* role they can play in this world of the health care during the period of *being adrift*, because it is in the act of acknowledging they can cause the death of Other that they too have to face their own mortality. In anxiety, they face up to mortality because they feel the fragility of life and the necessity of deciding what it all means. Simply stated ACNPs find themselves at a time during which they are being forced to realize the importance of choosing a possibility and defining themselves by it (Heidegger, pp. 293-301).

The ACNPs’ sense of responsibility to Other is not limited to the “face” of the patient. Indeed when ACNPs refer to the “level” of responsibility they carry, it is not an hierarchical level to which they refer, which would then have a tendency to diminish or denigrate the responsibility the staff nurse carries. Rather, it speaks to the different sphere of influence and layers of responsibility that ACNPs carry, which is different from and broader than that of the traditional bedside nursing role. When ACNPs write the order that will be carried out by Others, they hold the dual responsibility for ensuring that the right treatment for the right diagnosis/problem is ordered. ACNPs therefore hold the responsibility for being the “clinical” authority on the medical management issues, knowing that the health care professionals who carry out their orders “take on some degree of faith” that they are correct. The impact or consequence of a wrong diagnosis and/or treatment not only can result in a negative outcome for the patient, but it can also compromise the emotional and professional integrity of all the health care practitioners who act upon those orders.

Drawing from the work of Cassell (1987/1992) on her study of the work of surgeons, two other factors also influence the ACNPs’ experience of *being uncertain* as it relates to the new sense of responsibility they carry, increasing the complexity of their experience. The outcome of ACNPs’ actions are *attributable*; that is, the ACNP and patient, family and/or team, know who is responsible when events go well or poorly.

Also, as noted earlier, much of their work is now more *visible*; it occurs before an audience. The activities in which they are involved are a public act. Their actions take place before a specialized public composed of other professionals, who admire success and note defeat. Their every move is now more closely scrutinized and publicly judged. The glory of success is balanced by the fear and shame of public defeat. This is clearly revealed in the following three examples. In addition to the presence of the patient/family and nurse(s), oft times, the staff physician, residents, and other physician subspecialties, as is the case in the third example, are all present to observe the ACNPs in action. Subsequently, they are privy to the outcomes of their actions.

> It was challenging dealing with the parents because they were right there. ....The family was up in the unit while we were trying to intubate and you describe the procedure to them and then you have to admit **failure** in front of these people.
>
> Or if you're trying to start an IV in a patient who is very difficult and then you've got the family watching you and you know very well they want you to get it right away, somebody's called you and you're considered an expert and stuff like that but hey you just might not be able to get it, especially with somebody watching you.
>
> It was a baby with a heart condition and we needed to get a deep central line so you can run inotropes and different medications like that and it's easiest if you can just get it into the vein. And so you already have this line going into the stump of the cord and it was a little bit old, and then I'm suppose to find the vein, which is a very easy thing to do, but you have to cut the cord and this line was already in. Well needless to say for the first time ever I cut the arterial line while I was putting it in. I was trying to cut the cord for the venous line and I cut the arterial line. And well it just started shooting blood because it's in a major artery; I mean it was going to the aorta. So, okay, I didn't panic. I just had to grab it and then I just said to the nurse who was around, I said, "Get the doctor on the phone." ...And it got sucked into the body. It wasn't a matter of just cutting it. [tone of voice has gotten softer, calmer, and slower throughout this segment] Well, it got sucked in. ... And I'm thinking who can solve our problem? ...So the vascular surgeon, they have microscopic instruments and they kind of work with vascular things... So we paged them and somebody pages them STAT - it's just like we get half the hospital running in there because they think that one of their surgical patients is dying - and it was, "you didn't have to call them STAT, I didn't ask for STAT" [angry tone]. So then half the hospital is coming in, "What's happening? Who's coding?" "No it's not a code" [blasé , bored tone]. And then they say, "What shame!" You know, you have all these people racing in to find out what your problem was. ... ." And so ...he ended up doing a mini lap right there on the unit. And my face was burning, I felt like I didn't want to be there anymore [laughs] but I kind of coped until I was just thinking - God, how am I going to tell these parents? They weren't there, so that was better. If they had been there and I would have had to describe how these people, all these people had to get involved and what needed to happen to do that, I would have been much more mortified.

Thus, in the ACNPs' search to *be more visible* and *be more in control*, they paradoxically discover that both are terrifying experiences when living with *being uncertain*.

Being Lost

> 'Dear, dear! How queer everything is to-day! And yesterday things went on as usual. I wonder if I've been changed in the night? Let me think: *was* I the same when I got up this morning? I almost think I can remember feeling a little different. But if I'm not the same, the next question is "Who in the world am I?" Ah, *that's* the great puzzle!'
>
> ~ Lewis Carroll (1865/1971), *Alice's Adventures in Wonderland*, p. 17

> You know, one day you leave, you go to school, and the next day when you come back you're a different person because you do something else different. … I'm different because I used to be a resource person. I used to be the one who helped everybody, that tried to make everybody's life easier, the nurses, the patient, the family. I knew what the situation of the unit was because I had a broad perspective of what was going on. This was my role of being in charge. So I come back the next day and I don't know anything anymore. So this is difficult. It's the same place, I'm the same person, but I don't know anything anymore, because finishing school you don't pretend that you know the role very well, in terms of caring for children as a nurse practitioner. So this is difficult because you have to learn. And you're the same person, because I didn't change. I'm physically the same person. I could be of some help to nurses but in a different way but nobody, including me, knows exactly what I can do or what I'm allowed to do. And so I'm different, yes and no. But who am I? I'm different. I mean you're a nurse, I knew I was a nurse, but maybe I was trending toward the medical model at the time, because I focused a little bit too much in the NP role part and you know you're a novice and you just don't know who your are anymore.

Being lost arises from *being disconnected* and *being uncertain* and contributes to *being adrift*. It concerns not knowing who one is; it is the experience of a loss of identity. *Being lost* is about being in liminality and, as a result, is a constitutive element of *being adrift*. *Being lost* means that ACNPs are unsure of how to respond to such questions as: "Who are you?" "Are you a nurse or a resident?" "Where do you belong?" Instead, these questions are answered by asking more questions. Feeling overwhelmed with the prospect of all there is to learn associated with the "awesome responsibility" that goes with being ACNPs forces them to ask: "Can I do this?" and "Will I make it?" The constant state of fear and anxiety intermingled with intermittent experiences of exhilaration results in feelings of tension and confusion. The constant focus on the instrumental nature of their role leads them to query: "Is this what being a NP is all about?" "Could it be I am a physician substitute?" "Where is the nurse in the ACNP role?" "Where is 'the more' I was searching for?" "Is this what I really want?" "Should I quit?" These types of questions suggest that ACNPs experience being disillusioned in this period of *being lost*. Disillusionment is the internal perception created by role realities, and, as noted by Heitz et al (2004), it leads to self-questioning of why one endures the role given the internal and external challenges.

As new nurse practitioners, ACNPs are understandably slower than their more experienced counterparts in meeting the clinical demands of patient care management. Unit routines, which can be understood to be system demands, along with perceived physician and nursing staff expectations in combination with their own expectations for high performance, contribute to a pervasive anxiety about their abilities, which we have come to understand as a constitutive element of *being uncertain*. Needing to deliberate on, confer about, and check and double check everything they do while they attempt to assess and treat every patient by the end of the day, results in a "loss of time and opportunity" to engage in a relational ethic of care. As a result, there is an exhaustion and frustration with the lack of control they have over the situation, which is embedded in feelings of guilt and inadequacy at being unable to connect with patients and families. As a result of *being disconnected* and *being uncertain*, ACNPs do not immediately experience a feeling of having found "a fit" in the ACNP role. In fact, wanting to be more in control and to have more freedom to meet the patients' and families' needs in a timely manner seems more distant than ever. ACNPs express that is difficult to adhere to the ideals of holistic care and health promotion while responding to the various expectations of self and others, none of which even seem attainable. They express the constant struggle of holding on to "who they were" and "what they did" with who they are becoming as a result of what they are doing. Because of the situational pressures, they often feel it is difficult to hold to the NP ideals and establish a role that is different from that of physicians.

For ACNPs, *being lost* feels as if even the old world of nursing is far away and remote. Many ACNPs do not realize how loyal they are until they are away from their "home." Perhaps, just as darkness is often said to be the lack of light, *being lost* is the lack of homeness.

I feel that I am no one but a shadow
Of a shape I cannot see which haunts me,
And I exist in nothing like the cold dark.
~ Fernando Pessoa (1986)

It is as if the ACNPs' world has no centre, as if the rooms have been rearranged and they no longer know where anything is. As a result they become more aware of what belonging means to them. Simply put, a sense of belonging is re-experienced for the simple reason that they are a part of the community of nursing, and it is a part of them as well, but in being-in-the world in a different way, they experience being "but a drop of oil on the water" (Wu, 1991, p. 274).

> The meaning of the old world is often elusive. It is very hard to measure its volume. This body of water in the heart of a [stranger] can be as vast as an ocean, as it often occupies his or her whole inner world. ... I am homesick, but I don't know what I am missing. (Wu, p. 274)

A consequence of *being uncertain* is the inability for ACNPs to feel like a "real" nurse practitioner. Instead, feeling like an "imposter" or "fraud" is a common experience and contributes to *being lost*. It is as if the nurse is an accidental ACNP, landing the job purely by chance or luck. One ACNP related that it had taken her ten months before she no longer minded coming to work. Throughout this entire period she revealed that she felt as if she was "living with a false identity." An inability to articulate what it was she did and how to do it rather than "this is where I can be found throughout the week," contributed to a sense of homelessness and selflessness as an ACNP. Although this perception was augmented by the lack of a graduate degree and ACNP certificate, their eventual acquisition did not diminish the feeling of being an imposter.

> I didn't belong here; this wasn't home; this wasn't welcoming and I was an imposter in my role, very much. And you'll read lots of stuff, you'll find the work imposter is used, and I was kind of surprised when I found it in articles when I had been using that on my own even before then. Well I've got the title but I still didn't have my masters yet, I still didn't have my NP certificate yet, and yet I'm in the role, and I'd been in the role for a couple of years before I finished all the schooling pieces, only to then realize that the schooling pieces didn't shape how I functioned as much as just the experience on the floor shaped it instead. It's not the book learning in this case anyway. [laughs lightly]

When one feels like an imposter there is as sense that one is "not real." Newly graduated ACNPs may be properly licensed to apply the advanced knowledge and skills denied to other nurses and have all the professional qualifications to practice as ACNPs, but feeling like an imposter is an experience born out of *being uncertain*. ACNPs feel as if they are trying to pass off as someone with qualities or traits that they do not possess. When we reflect on feeling like an imposter we might say "we feel like we are trying to pass off as an insider while being an outsider to a special group of people who all have the qualifications and characteristics that they do not have" (Altrows, 2002). We feel separate and out of place, different from "others." We are plagued with nagging self-doubts and a fear that our colleagues will discover that we are not one of them.

But for ACNPs, who are the "insiders" to whom they feel like outsiders? Is it nursing? Is it medicine? For most, it cannot be a NP group to whom they feel like outsiders, because as pioneers, ACNPs frequently work as an N of one within their practice settings and sometimes even within their institutions and regions. Most do not even share a past with anyone, for in Canada, ACNPs are nurses with a limited history. Therefore, on the one hand, the experience of *being disconnected* helps us to see that ACNPs can feel like they no longer belong to nursing without feeling like imposters. On the other hand, by the very nature of working on the margins of the medical community of practice, particularly during the time of *being uncertain*, ACNPs may feel they are physician imposters, or at least medical resident imposters. As a result, they may feel that they are not who they "should" be and are somehow falling short of the expectations and standards for someone in that position. And yet this is not quite true either, for ACNPs know that they are not physicians, despite needing to have some of the knowledge and skills that are possessed by the group.

Perhaps feeling like an imposter, an element of *being lost*, is not that ACNPs fail to measure up to the persons they are supposed to be, but that they fail to see who they truly are. ACNPs qualify for the positions they occupy, and are deemed competent at what they do for the level of experience they have attained (e.g., as signified by a license to practice). But part of feeling like an imposter is that the ACNP believes that everyone else fits the ideal except them. But what is the ideal ACNP? Who are they comparing themselves too? For a few ACNPs, they compare themselves to other ACNPs they have seen "in action" during their educational experience or to other ACNPs within their own practice setting, such as the neonatal ACNP groups. For others, they have created their expectations for the ACNP role based on a combination of the discourse (e.g., ACNPs perform at the level of a 2nd year resident), their own personal expectations for the "ideal" performance in the clinical arena, and the expectations of those to whom they report in the work setting.

> [This ACNP during training] she seemed to know everything. Now I had no clue when I started that the reason she was spending so much time down in the radiology department was because she knew she didn't know how to read chest x-rays properly, found out who would be the best person in the department to teach her, and went to him to ask him to mentor her and teach her. So I just assumed she knew everything, never even acknowledged that she didn't. If she said something, it was gospel. I wasn't going to question it because she knows. It was the way she carried herself - she just had a presence about her. ...And I remember when I started and she'd go through the list - GSW, GSW, GSW - and I'm like, "Oh my word. This is like ER." You know I could never do this. You know I want to be back in my little post-op unit when they're already patched up and put back together. Don't expect me to know how to put them back together because I don't know that part of it." So her presence, her way of carrying herself and speaking, it was a lot of acronyms and you just got the sense - there wasn't even a resident affiliated with team; she was the resident and the nurse. So that's when I first met her. I didn't even see the nursing part of what she did, I just knew she was a nurse who knew God more than I'd ever know, and seemed as knowledgeable as a physician and worked in a field that boggles my mind, but she was able to pull it all together. She seemed to know everything. And it wasn't until long afterwards that I could see her doing the nursing piece, the counseling with the patients and their families because I was just too caught up in the medical efficiency piece she did. .. I didn't even know that I didn't see it that way until I'd been in the ACNP role for quite awhile.

ACNPs experience an acute awareness of how others may see them. There is a sense of split between the "I" who experiences the world through their own eyes and the "me" who they see through the eyes of others. They experience a sense of nakedness or transparency in the eyes of a real audience. As they squirm under the other's gaze, they fear being found out for who they "really" are behind their façade. They are afraid that if others were to know the truth about them, the others would feel betrayed or disappointed. The others would think that they had made a terrible mistake in respecting them as ACNPs or placing their trust in them, with the consequence that they could be rejected or disgraced. In feeling like an imposter, they fear being revealed for who they are. They tend to live with a sense of dread and foreboding that it will only be a matter of time before they are found out. It often results in this sense of incredulity that others actually have placed their confidence in them.

> And I always thought it was strange when I would see a patient and then I would say to the patient, "Do you want to see the nephrologist today?" And they would say, "No, I don't want to see the nephrologist today." And so they wouldn't. They would just see me, their NP. And I always thought that that was so bizarre and strange. And you know the physicians would seem quite confident for that to happen, that I would have my list of patients to see, the resident had theirs and the physicians had theirs. So it would seem whole days would go by where I didn't need to double check something with the physician and at the end the patients didn't want to see the physician. And it always felt so strange that they seemed to have an overwhelming confidence in me. They probably had more confidence in my decisions than I did at the time. I always felt strange about that.

Is there something about performing the ACNP role that makes the ACNP feel like an imposter? The word "role" is derived from the Old French *roule*, referring to the roll of paper on which actors' parts were written (Trumble & Stevenson, 2002). Roles are scripted "parts" or functions that an individual is expected to perform in specific situations and contexts. A role is a set of expectations, standards, and guidelines for how to behave, think, feel, and present oneself in a particular social position. ACNPs are presenting themselves in a way that makes them feel uncomfortable. Their manner of speaking, their position within the group, feels like a public façade that masks their private experience. Do they feel like imposters when they present this façade to other people? Is this made worse because they are doing so in front of other nurses who continue to remain predominantly invisible in this venue? Is it made worse because they do not know what manner of expectation is expected of them as ACNPs?

But perhaps being an imposter is even deeper than these elements reveal. Is there any connection to feeling like an imposter with the questions that concern ACNPs during their experience of *being adrift*, questions such as, "Who am I? Where is the nurse in what it is I do as an ACNP? Am I a nurse? Am I a resident substitute?" Perhaps ACNPs feel like there is a layer surrounding and concealing who they really are when they can be only focused on what they are learning and doing within the "medical" sphere of their role. At some level, ACNPs are aware that although they are playing in a role, they are not yet this role. It may be that they do not yet completely identify with it. In this sense they are betwixt and between, in a state of liminality. Perhaps this is best conveyed by poetry, not by prose. Three selected verses from T. S. Eliot's *The Hollow Men* (1974, pp. 81-82) describe this sense of liminality.

Between the idea
And the reality
Between the motion
And the act…

Between the conception
And the creation
Between the emotion
And the response…

Between the desire
And the spasm
Between the potency
And the existence…

To identify with a role means to feel an association or likeness to it, or to see one's self in it. The more we identify with a role, the less separate and distinct we feel from it. Conversely, the less we identify with a role, the more aware we become that we are not the role we play. Is it possible that feeling like an imposter means that the ACNPs are not yet able to identify with what it is they are doing because it doesn't yet feel morally like who it is they are? Does this cause them to feel further distanced from their nursing colleagues? It has been recognized that the instrumental doing and rationale thinking stands outside of the philosophical foundations of nursing when it is not embedded in a relational ethic of care. Wicks (1998) wrote that nursing celebrates closeness and connectedness in a relational approach to care that links the physical with the emotional aspects of caring. Perhaps ACNPs become uncomfortable when they experience a disconnection of themselves and their role, which is the experience of *being lost*.

The irony about being betwixt and between, perhaps considered as a place of twilight, is that ACNPs often make interesting discoveries about themselves as nurses. *Being lost* is a form of un-knowing what was previously known and knowing these things anew, a constant trying on roles for size and evaluating how well they fit with who they are. "When we find a role that suits us, we may become so identified with the role and so accustomed to it that we forget that it is a role at all. It is as if we become asleep to our true selves" (Altrows, 2002, p. 9). Just as Altrows suggests, perhaps the experience of feeling like an imposter as an ACNP comes with their awareness of the ever-shifting tension between themselves and the roles that they play. Without this awareness, they risk losing themselves in the role, thereby losing the freedom to try on new roles and discard those that no longer fit. In the end, the experience of feeling like an imposter may awaken the ACNP to their true selves and what it means to be free (Altrows, p. 10).

In being immersed in learning how to "think like a physician" ACNPs discover that they "think like nurses." In discovering what it means to "think like nurses," they re-new previously taken-for-granted values. Yet, now they experience a fear that that which they value will be compromised or lost altogether in this new role. When, for example, ACNPs are required to remove the psychosocial information from their notes, they are reminded that physicians' time is too valuable to be wasted with this "less important" way of knowing the patient and family (interpreted to mean that information gathered by nurses is not significant). Even the idea that ACNPs must work out for themselves how and what to write in the medical progress notes is taken to mean, "You should be able to work this out and if you can't then you are inadequate." This reintroduces the notion of "sacred" knowledge (Turner, 1969) and reinforces the relationship of dominance and subservience, along with the dread of being revealed as inadequate to the task, an imposter. Once again, ACNPs are forced to reconsider their career choice. Will they be able to work it out on their own and thus prove they are capable? Will they get the autonomy they desire in the role or is this more of the same they experienced in the traditional nursing role? Will they be able to integrate that which they value in nursing with that of medicine or are they being trained to be "mini docs?"

ACNPs re-cognize what it means to be a nurse through what it is they do, which is brought to their attention by physicians, and by what it is they are not able to do, which they miss (e.g., being connected and a provider of holistic care). This re-cognition puts them on alert. Like standing in front of a mirror, they notice a lot of things about themselves that they did not see before. A re-cognition of "me" occurs. Yet, this "me" is not the "self" they are familiar with. The mirror the ACNP is facing is a distorting mirror. The person in front of them is not what they had expected to see. Some ACNPs may even become cautious and carefully adjust themselves to make a better image depending on the community of practice with whom they are engaged. This is not an easy period at all. Being a stranger, they cannot satisfy themselves with what they do. Their eyes become so keen that all they can see is their flaws and what they are not. They are not only a stranger to others, but are also becoming a stranger to themselves. They are lost. Who should they be?

Is it my clothes, my way of walking,
the things I carry in my hand

this space cannot hear

or is it my own lack
of conviction which makes
these vistas of desolation

The others leap, shout
Freedom!

The moving water will not show me
my reflection.

The rocks ignore.

I am a word
in a foreign language.
~ Margaret Atwood(1970/1997)

Being lost then is to be a stranger in a strange land. It is the discovery that when one is a stranger, one is always conscious of one's own self. Daly's (1997b) article, "*Strangers in a Strange Land,*" provided the impetus to revisit the critically acclaimed science fiction novel by Robert Heinlein (1961). It is the story of an Earthling, born and educated on Mars. Earth's astronauts eventually discover him living with the Martians, a race far advanced beyond Earthlings in culture, morality, and intellectual capabilities. The young man is brought back home to Earth, but discovers Earth is not at all "home" to him. Even after learning to speak and dress like humans, and understanding their motivations, hopes, and shortcomings, he finds himself a "stranger in a strange land" because he is unable to fully grasp and experience the essence of being human. The story describes the tension between the efforts of the stranger to assimilate human values and conduct, the efforts of those around him to teach him these ways, and a fundamental resistance to this metamorphosis born of his exposure to a different kind of morality and way of being in the world.

ACNPs come to their role understanding their way of being in the health care world from a nursing perspective, an understanding built on a tradition of holism and embedded in a moral framework that reflects a predominantly female profession. This is a perspective that is more often particularistic and subjective rather than objective and distant, as is the medical perspective. But under the circumstance of becoming an ACNP, their focus shifts from dwelling within the healing model, with its emphasis on knowing the patient fully and holistically and optimizing health and comfort, to the notion of patient as body to be observed, known and treated, using language of domination and control as is evident in the scientific model of medicine (Gadow, 1980). They spend their days focused on deductive reasoning, constructing hypotheses, using established procedures and algorithms. During this period, the dominant aspects of their role are both mechanistic and reductionistic. They are continuously informed that if they have the right facts and a full understanding of the pathophysiologic processes, they will be able to predict and control events. They are explicitly told to "stop thinking like a nurse" by their physician colleagues. Through their concentration on more and more detailed aspects of physical "malfunction," it is not only easy for the ACNP to lose sight of the patient, it is almost essential that it happen. In this way the focus is kept clear and energy consolidated while they learn what they need to learn in order to perform safely when clinically caring for their patients as ACNPs.

> So where's the NP in what I do? That's the challenge. At the beginning, people referred to me as a resident. Nurses were calling me, "Are you my resident today?" And I'm not your resident today; I'm your NP today. And I think that was because the training was fairly medical – so it was a struggle getting away from the fairly medical training and bringing back the good that I got in nursing training and putting it together. So that's the challenge and struggle learning to be an NP.

But this language and focus for being, however necessary, feels foreign and "wrong." The focus of this learning involves a detachment or disconnection from the suffering and pain of the patient, and although "the art of describing facts is the supreme art in medicine: everything pales before it" (Foucault, 1963/1994. p. 146), it creates a struggle for ACNPs. Some ACNPs are torn between their admiration for the "coolness and presence of mind" needed to perform well in this role, particularly under pressure, and a fear that to acquire that level of knowledge and skill will require the sacrifice of the philosophical tenets of nursing. In order to master the knowledge traditions within medicine, along with being situated within the medical world, albeit on the edges, they question if they will have to give up their connections to nurses, nursing, and the patients/families. It makes them feel as if they are severed from those for whom they care most. It seems to contradict one of the main goals of the journey – to be more connected to Other. The relational character associated with closeness and being connected is perceived as anathema to the dominant, distancing, and objectifying discourses of scientific medicine. While in medicine involvement is a by-product of the quest for knowledge, for nursing it is a central and pleasurable part of the nurses' work (Wicks, 1998). In this sense, whole days, weeks, and months spent predominantly in discourses that focus only on objectification of the patient with limited time for relational activities are in opposition to what ACNPs value and thereby create an internal struggle or tension. Given that ACNPs have chosen to remain in nursing yet feel a loss of connectedness to what it is nurses do, they experience a kind of longing.

The experience of *being lost* is not simply related to what ACNPs are going "to do;" *being lost* fundamentally concerns who they are going "to be." This internal struggle forces them to question their loyalty to their profession and to their new career choice. They begin to question if they are severing the bond of kinship between themselves and the Others they care about. They ask themselves if they are engaging in acts of complicity when they focus on those aspects of medicine that are predominantly focused on illness and treatment. Are they co-opting their values related to nursing for goals that are not achievable except at the expense of those values? What do they have to lose to gain?

[17] The process of inner conflict can lead to great distress. In fact, learning to care for patients from a medical perspective is not only destabilizing but also polarizing. During this time of *being lost*, ACNPs experience this struggle as needing to make a choice between a practice with autonomy and skill based on the scientific paradigm and a practice within a "cosmology of healing" (Wicks, 1998, p. 72). *Being lost* is experienced as an either-or/neither-nor phenomenon, a dichotomy of two mutually exclusive and contradictory paths. From this new view point, their past is severed and they have become two unconnected pieces. "Thinking like a physician" is experienced as oppositional to "thinking like a nurse." Thinking more like a physician implies thinking less like a nurse. It is experienced as moving to the physician side of health care, which implies they must leave the nursing side. Am I a nurse or am I a physician replacement? This question inhabits their entire being.

Being lost makes them feel like their own "self" is falling away. There are two "I"s. These two "I"s are perceived as dichotomous, bipolar, and opposing each other. There is the nursing "I" with whom they are familiar and with whom they feel connected. This is the "I" they enjoyed and were proud of and desired to promote and enhance when they chose to depart on the journey to becoming an ANCP. They are still proud of that "I" and do not want to let it go. The other "I", the "I" engaged in traditional medical acts and seen externally, is a stranger. This "I" is like a distorted figure who always appears whenever they experience being a stranger in a strange land. They cannot accept it as is because this is not what they want, but they cannot reject it because it is becoming part of their new self. The new knowledge and skills they are acquiring are necessary to be more challenged, more visible, and more in control. Yet, their old self clashes with their newly discovered self. *Being lost* means that ACNPs possess a disorganized inner world and inhabit an unconnected outer world and as a result much of their world as an ACNP is experienced as paradoxical.

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[17] Photographs of unmarked sculptures taken by J. Rashotte, October 2005, in the public grounds of the Adelaide Convention Centre, Australia

> To be a castaway is to be a point perpetually at the centre of a circle. However much things may appear to change – the sea may shift from whisper to rage, the sky might go from fresh blue to blinding white to darkest black – the geometry never changes. Your gaze is always a radius. The circumference is ever great. In fact, the circles multiply. To be a castaway is to be caught in a harrowing ballet of circles. You are at the centre of one circle, while above you two opposing circles spin about. The sun distresses you like a crowd, a noisy, invasive crowd that makes you cup your ears, that makes you close your eyes, that makes you want to hide. The moon distresses you by silently reminding you of your solitude; you open your eyes wide to escape your loneliness. When you look up, you sometimes wonder if at the centre of a solar storm, if in the middle of the Sea of Tranquility, there isn't another one like you also looking up, also trapped by geometry, also struggling with fear, rage, madness, hopelessness, apathy.
>
> ~ Yann Martel (2002), *Life of Pi*, p. 239

Operating from a dichotomous position is not dissimilar to this passage taken from Yann Martel's (2002) critically acclaimed contemporary novel entitled *The Life of Pi*. The story concerns the transformational journey of a sixteen-year old boy named Pi Patel, who, after the sinking of a cargo ship, finds himself alone, for many months, on the only surviving lifeboat stranded with a small group of wild jungle animals. *Being lost*, being a castaway, as was the case with Pi, demonstrates what it is like to be "caught up in grim and exhausting opposites" (p. 240). On the one hand, what ACNPs originally seek on this journey seems to have collapsed in front of them into pieces and becomes elusive to grasp. On the other hand, this new world is experienced as in your face, gigantic, and overwhelming, making them feel small and dwarfed in this unknown but powerful world of medicine.

> And I started writing orders and people started doing them, which I found very [laughs], you know, that's odd, why are they doing what I'm telling them to do? [laughs] Don't they know I'm just like them? Here I'm, this role I felt very much, not powerful, but you know, that you have the final say, and what you say goes, and people are actually listening to you.

Similarly, how can ACNPs feel like they have no centre when they also feel as if they are perpetually at the centre of the circle? As Pi reveals, "when it is light, the openness of the sea is blinding and frightening. When it is dark, the darkness is claustrophobic. When it is day, you are hot and wish to be cool…when it is night, you are cold and wish to be warm" (p. 240). Equally, when ACNPs begin to experience the overwhelming nature of carrying the responsibility that comes with autonomy of practice, they immediately seek solace in the ultimate responsibility belonging to the staff physician. When they are called upon to defend their choice of action, the visibility is frightening. As Pi discloses, "the opposites often take place at the same moment, so that when the sun is scorching you till you are stricken down, you are also aware that is drying the strips of fish and meat that are hanging from your lines and that it is a blessing for your solar stills" (p. 240).

> When you're first doing [intubations] you're not sure that you can repeat it even though you've done the skills; like can you do it under this pressure and can you do it in that situation? But at the same time, when you did it, it was like, "Oh, I did it! I accomplished it! It's great! This is such a great day, I did this and this." [tone very animated and excited] I mean you think of it as procedures and stuff, but you know, "I went on a transport," [excited] and then we complain because it was a sick baby but I know from doing it myself, that **that** was the greatest satisfaction [each word slowly stated], so it's like a complain-brag, you know. "I did this," [bragging tone] and it's great.

ACNPs are exhilarated when they successfully perform their first intubation, witnessing the patient's immediate relief from respiratory distress, while simultaneously realizing they will be expected to perform the next intubation alone, terrified that they will not be successful. There is an excitement and exhilaration that comes with being successful in the advanced instrumental nature of their practice, along with a feeling that they have made a difference in the lives of their patients. It is during these fleeting moments that ACNPs experience moments of real pleasure, a glimmer of the "perfect fit" for which they are searching, a feeling of being close to home. Yet at the same time, they feel a failure in the provision of the holistic nature of their nursing care. As Pi considers, is this swing of the pendulum from exhilaration to terror not the worst pair of opposites with which to live, particularly when they are experienced in the same moment? For indeed these two opposites do not remain distinct. Life at the time of *being lost* is not much of a life. As Pi reflects on *being lost*:

> It is like an end game in chess, a game with few pieces. The elements couldn't be more simple, nor the stakes higher. Physically it is extraordinarily arduous, and morally it is killing. …You reach a point where you're at the bottom of hell, yet you have your arms crossed and a smile on your face, and you feel you're the luckiest person on earth. (p. 241)

In this time of *being lost*, ACNPs undergo a disintegration, and a reorganization or reshaping of self is needed to regain peace and confidence. In so doing, they undergo a profound change, a change that is irreversible. This process is threatening, as ACNPs have to alter their identities in order to accept this transformation.

> 'Who are you?' said the Caterpillar.
> This was not an encouraging opening for a conversation. Alice replied, rather shyly, 'I – I hardly know, Sir, just at present – at least I know who I *was* when I got up this morning, but I think I must have been changed several times since then.'
> 'What do you mean by that?' said the Caterpillar, sternly. 'Explain yourself!'
> 'I ca'n't explain myself, I'm afraid, Sir,' said Alice, 'because I'm not myself, you see.'
> 'I don't see,' said the Caterpillar.
> 'I'm afraid I ca'n't understand it myself, to begin with; and being so many different sizes in a day is very confusing.'
> 'It isn't,' said the Caterpillar.
> 'Well, perhaps you haven't found it so yet,' said Alice; 'but when you have to turn into a chrysalis – you will some day, you know – and then after that into a butterfly, I should think you'll feel it a little queer, wo'n't you?' (Carroll, 1865/1971, p. 40-41)

Staying Afloat

Adrift! A little boat adrift!

Adrift! A little boat adrift!
And night is coming down!
Will no one guide a little boat
Unto the nearest town?

So sailors say – on yesterday –
Just as the dusk was brown
One little boat gave up its strife
And gurgled down and down.

So angels say- on yesterday -
Just as the dawn was red
One little boat - o'erspent with gales-
Retrimmed its masts - redecked its sails -
And shot - exultant on!

~ Emily Dickinson (1858/1976)

It has been revealed that in the experience of *being disconnected*, *being uncertain* and *being lost*, nurses on their journey to becoming ACNPs lose the taken-for-granted way in which they used to work as nurses. As a result, the call of conscience is experienced as a conflict between two styles of existence. During this time of tension and struggle, ACNPs are being called to "choose to choose" and to inhabit the present by seizing the opportunity to listen to their conscience and to take the responsibility to make something of themselves on the basis of who they already are (Heidegger, 1927/1962, pp. 318, 344). This may mean choosing either a very different course for their nursing career or to struggle to *stay afloat* during this time of *being adrift.* In either case, they are being called to gain a clearer understanding of who they are, what is truly important to them, and what they need to do in the nursing world. They are being called to enter into "the situation" (Heidegger, p. 346), to find an authentic way of being as a nurse. As Heidegger opined, genuine decisions involve taking a risk in the context of a unique situation. During this time of *being adrift* they are being continuously requested to authentically reaffirm their desire to be ACNPs and "the more" for which they are searching.

Heidegger (1927/1962) cautioned us that "even resolutions remain dependent upon the "they" and its world" (pp. 345-346). All the interpretations of what nurses experience as ACNPs during this time of *being adrift* are filtered through the "they" (such as nurses and nursing, physicians, other health care providers, patients, society in general, their own families). In making a choice, each ACNP gains an initial understanding of what these options mean through the "they." The possibilities for their existence as ACNPs are furnished by the "they," which each nurse then makes as a possibility for him or herself. But in choosing to struggle to *stay afloat* ACNPs are ultimately called into action.

The turbulence and chaos experienced in *being adrift* creates a need for stability that is achieved by the influence of positive forces. Even as the scenes of destruction wash over them, there is a germ of rationality that begs to be heard. Is it not true to our own experiences that the little voices in our heads insistently intrude on our panic: "Get yourself together. There is no reason to think you can't do this"? Rationality struggles to calm the emotions long enough to allow the hope that we can succeed to find an entrance. In a similar manner, ACNPs use what Heitz et al. (2004) referred to as "optimistic self-talk," a form of internal reinforcement that helps them maintain a positive mental attitude as a personal coping mechanism throughout this time of *being adrift.* They repeat to themselves comments such as "You've got to keep working" and "You're prepared to do this." It also reveals the shear grit and determination so frequently demonstrated as part of the pioneers' character in such classis novels as Willa Carther's

(1913/1997) *O'Pioneer*, and James Fenimore Cooper's *The Pioneers* (1823/1925) and *The Last of the Mohicans* (1826/1925).

Staying afloat, despite the turbulence experienced, in fact becomes its own positive motivator. The will to succeed is a matter of pride, a need to hold on to the belief in their abilities and the right to successfully discover "the more" for which they are searching. *Staying afloat* is about refusing to be a sacrificial pawn in the health care game of resource management or a *peon* who is just another physician's foot soldier or servant. Preparing the way for others to follow and being successful in meeting this challenge are part of the rewards of journeying through *being adrift* and ACNPs hold fast to the possibility of their attainment. Living through the struggles and tensions is perceived as a necessary sacrifice to experience the rewards.

> I'm not the kind of person who likes to give up and admit failure. I guess I'm stubborn in that way. I have some sense of pride in what I do and I just think that I wouldn't admit that this was something that was too much for me. And you always think that it's going to get better with time.
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> I think the challenge of being the first graduate nurse practitioner in the province was something that keeps you going. You say, "Well, we're going to be the first ones out; we're going to be out of the gate before everybody else." So that kept me going. Also, I think it's a bit of a pride thing to keep going.

All the feelings associated with *being uncertain* need to be quickly contained if one is to survive living through the experience of *being adrift*. There is a strong need to "get resolution of it pretty quick"; "It's like how long are you going to sit in the office and worry about this before you go find a physician to just give you that reassurance or just that clarification so you can sleep at night, that type of thing?" Although the ending of their journey is uncertain, ACNPs must minimize that uncertainty, demonstrating the motivation and action that are key features of their employment and required to move their story forward and arrive "...where one longs to be" (Mattingly, 1994, p. 253). ACNPs discuss *being uncertain* as an issue that requires their active engagement and attention. They describe that in *being uncertain*, they must actively employ ways and means to successfully face and overcome their uncertainties. Therefore, during this time, ACNPs do not sit idle; there is a need for action. If *being uncertain* is seen as a challenge, then there is a requirement to engage in a battle to subdue it.

> I guess the challenge is what keeps me going. I'm one of those "keep-going" persons. ...If I find that the challenge is becoming uncomfortable then maybe I need to do something about it because that does not give me satisfaction.

Indeed, *being uncertain* becomes a catalyst for action. In this way, jumping into the fray, studying, and using their worry to promote learning and professional growth become strategies for coping with their worries. Perhaps it is as Herman Melville (1851/1992) wrote in *Moby Dick*, "I have swum through oceans and sailed through libraries." ACNPs speak to the need to simply immerse themselves in a constant state of learning and as such academic learning is seen as a positive force. They recognize that the theoretical knowledge and skill they have acquired in the formal classroom setting is but the tip of the iceberg, a mere pittance of what they need to know. In fact, "the more you learn, the more you want to learn; Oh I wish I knew a bit more and then a bit more, and then a bit more after that."

> I think initially it was very stressful in that I felt that I didn't have the experience or the education to do those things and so I did a lot of reading, I went to a lot of the physicians' rounds to pick up that knowledge that I needed before I could make those decisions.

> I mean you always bring your books with you. You've got your handy dandy handbook that can give you your medication dosages and your calculators and all your various reference checks.

But the key issue during this time of *being adrift* is to be able to mobilize problem-solving skills enough to function and meet the responsibilities of diagnosing and treating patients. "Doing and learning at the same time" become essential partners. ACNPs recognize that theoretical knowledge, "knowing that" (Schön, 1987), must be translated into "knowing how." As one ACNP articulated, immersion in their work as clinical practitioners is critical.

> Well I think sometimes you just have to pluck up the courage to just say it, just write it. ... I mean my pockets are full of stuff because I always want to have a back up if I'm not sure. I never write stuff if I'm not sure about it. I need to be sure about what I'm doing and so I have the *NP's Guide to Diagnosis and Treatment* or whatever and my palm pilot has different things in it.

ACNPs look for ways to deal with the fear and anxiety that come from the worry associated with *being uncertain*. Worried or anxious about the harm they may cause to their patients as a result of the mistakes they could make in clinical decision-making, ACNPs strive to create a safety or life line that will protect both self and Others. This safety line comes in a variety of forms, most of which are used repeatedly, frequently, and concurrently. Just like the lifeline built around the deck of the boat or the tether ropes attached to sailors as they climb the foremast to the crow's nest, each serves to keep the ACNP and the patients safe from harm. For example, similar to the principle of worry beads that are constantly worked by the fingers to calm the nerves, some ACNPs "repeat" themselves "four or five times" in an attempt to satisfy themselves that they are "doing it right; that it's correct, and nothing bad's going to happen." Checking and rechecking their work and asking the same question multiple times or of multiple people are also natural responses to being worried and are ways that encourage confirmation that the right action will be taken. There is a hope that someone will be alerted to a potential error and then will catch them before they do harm to others or themselves.

> I came back; I reviewed the chart; I looked over everything and decided that yes it is done right. This is what should be done; everything is correct; okay, now stop it; now go home. But you know, there's one or two things that just pop into my head and it's like, well it's either go back or I'm up all night reading a CPS. ...And sometimes that's what I have to do.

Even the actual process of engaging in the diagnostic reasoning process itself becomes understood to be part of the safety line. Examining all the possible causes for the patient's signs and symptoms along with the most likely reason become the way to ensure no stone has been unturned.

> You always build a safety net - so that your assessment might lead you to believe this is what the issue is, but you always want to build a safety net in case you make a mistake, so that you're not exposing the patient to risk. So this is what it most likely is but just in case it's one of these more serious things, I'm gonna protect the patient. So the focus is always on protecting the patient and making sure that the patient is not exposed to unnecessary risk.

For the first few years, the ACNPs' priority is to get the knowledge and skill they need to be seen as competent. Therefore, weeks into the new role, the ACNPs begin to develop their own navigational chart. "Being practical" people, trained and experienced in the ways of nursing, many ACNPs look toward the immediate development of policies and procedures in the form of protocols, clinical guidelines, or medical directives that serve as maps that can help them safely navigate through the clinical decision-making process that is required of them.

> And I developed protocols for certain things that I do that would sort of guide me along. Like how I deal with somebody who's bleeding, or how would I deal with somebody who is having arrhythmias, and sort of what pathway would you take, and having the clinical guidelines with the knowledge and the theory behind what you do and those kind of things. Versus just doing what the doctor tells me I should do, or this is what the doctor does so this is what I should do.

These guidelines and directives serve to anchor them to something that feels solid, sure, and stabilizing at a time when they feel as if they are free floating with the currents and tide, not under any control. If artifacts and practices are not available for adoption [which normally enables engagement with our community of practice and contributes to shaping the relations of accountability by which we define our actions as competent (Wenger, 1998)], then they must be constructed through a process of negotiation. The interesting outcome of the process of the formalization of these new "practices" is that it allows ACNPs to engage with others around the dimensions of the various practices in which they may be involved. This then affords them the power to negotiate their enterprises and thus shape the context in which they will work, and begin to experience an identity of competence. In addition, the creative character of the imagination it requires to construct the guidelines and directives is anchored in social interactions and communal experiences and thus is a mode of belonging.

The following example demonstrates the construction of these artifacts within one situation. Within the first month of being in the role, the ACNP was informed by her Director of Nursing that the hospital could not legally support her in the engagement of any activities outside of this scope of practice. This was despite the fact that she fully recognized the ACNP role as an expansion of the nurses' practice outside the traditional scope of the registered nurse and one the hospital philosophically supported. Attempting to deal with "the mixed message" she was receiving of "do the job but don't step outside the scope" was clearly a challenge of being a pioneer. However, this challenge set into motion the creative process of negotiating a scope of practice that would be acceptable for both her subspecialty and broader institutional communities of practice, as well as establish a structure that would legally protect both her and the institution. The passage reflects the ACNP's attempt to create a context in which to proceed with her working life and a way to maintain a sense of self she could live with in this new role. It demonstrates that ACNPs develop a sense of belonging and their sense of identity in larger contexts – historical, social, cultural, and institutional – with specific resources and constraints. It reveals that to do what they are expected to do ACNPs create a practice with an inventiveness that is all their own.

> So I mean one of the things that became clear very quickly was in order to be effective I needed to have medical directives. They'd never been devised at the hospital before; no one had ever done them before. There wasn't a lot written on them at that time. ...And I said, "Okay. Well we need to do this because you know I have to have some structure to order analgesics, to order IV fluid. I have to have some way. I can't just be ordering these things. There has to be a structure that protects me legally, protects the institution legally." And because there was no template at that time, although I did receive advice from the College of Nurses, I developed what seemed workable for me which was approved by the physicians.

This ACNP's story also illustrates that where there are obstacles there are Athenas and Chirons ready to assist ACNPs in navigating them. Sometimes ACNPs have to actively seek their assistance, while at other times, they need only to seize the opportunities that are presented, a finding similarly revealed in the work by Reay, Golden-Biddle, and GermAnn (2006).

> But it was blocked by my director at the time because she wasn't too sure about it because, while she'd acknowledged that I needed it, she wasn't sure if it was the right time to present it to the organization. So I got quite frustrated because, you know, I was practicing and I was trying to find a way to make sure that I was covered legally but I wasn't getting the support. I was getting physician support but I wasn't getting nursing support. So what I actually had to do was to run around using the political structure. So I actually had made good friends with a nurse who was on the committee - I can't remember the exact title, but it was the committee that looked at all practice related stuff - and so I was talking to her about this and explaining my frustration and she said, "Why don't we just do a back door thing." She said, "You give it to me and I'll take it to the committee for approval without going through the director," because this committee could approve it. And she said, "Once it's approved, she can't say anything." And well I said, 'Okay lets do that' [laughs]. So she took it, you know, which was a bit of a risk on her part because the director might come after her. But the committee approved it, no problem. And it was interesting because the director was like – "Oh they approved it. Okay. Well." But I was like, you know, I can't practice in this vacuum. ... So I was quite happy when that got approved and then I can sort of be on firmer footing to do some of these things.

As this ACNP noted, "When you're the first one there, there's no process, and people don't really know what the process should be," but having met the challenges of being a pioneer, "all the policies, procedures, and protocols, are now in place for NPs starting today." The ACNP appreciates that within her institution there are "lots of past experiences on how we handle this type of situation." In other words, there is now the beginning of a history to be shared, a history that facilitates new NPs' sense of belonging within the community of practice, at least within this institution.

The need for a safety line in the form of directives or protocols is made more evident when it is revealed how confusing and frustrating it is for those ACNPs who work in a province where this concept is non existent, and legislation denies them any rights to advance their scope independently into the arena of prescriptive and diagnostic authority. These ACNPs describe how they "need to constantly cover" themselves, all the while feeling like they are "walking on eggs." Not "being covered or fully certified," they feel in-between two groups, constantly confused as to their status, and frustrated that they have "not been recognized as an entity."

> Giving a diagnosis is a big NO in our province. But how can you decide on a lab test, how can you decide a plan of treatment if you can't say that you saw pneumonia on the x-ray? You know that there's a pneumonia there but you can't say that there's pneumonia, but you can write an order for antibiotics. And so we say it's a pneumonia not yet diagnosed. ...Well actually I have to go to one of the fellows and say maybe we need to start antibiotics because the child has a fever, because the white count is high, because of the type of secretions and because of the findings on the x-ray. And then I write the order and I have to get the fellow or the staff physician to countersign it.

As a consequence of "not having a solid basis in terms of legal recognition, or in the use of medical directives," these ACNPs create a safety line by "always backing themselves up" by having "everything countersigned." But as a consequence, these pioneer ACNPs frequently find themselves struggling with the tension of "playing politics" and "doing footwork" for the physicians, both of which negate the raison d'être for the journey.

> I cannot work without my physician colleagues being there. Within this hospital we only work when there's an attending physician in-house as an NP. So this makes it a relationship where I totally depend on them to be here and in a sense they depend on me because a lot of what I do is foot work - call for tests, call consultants, speak to people. And sometimes that's frustrating. It just depends on how I look at it. It depends if it's a priority for me. If I see it as this is my patient, this is the plan of care, this is where I want to go, then it doesn't bother me because that's what I do. If I'm doing foot work in the sense that I'm calling people and doing things which I don't think are necessary for my patient or appropriate, then I feel like I'm doing foot work. Sometimes if I've tried my usual avenues and I'm not getting anywhere and then I speak to my attending and he says well then call so and so, then that annoys me because I have taken it to where I can, and I'm starting to play politics and stuff like that and I don't find that's part of my job. You know if a consultant is not willing to come and he's not providing me with the answers or the treatment that he needs to be providing me, then I feel that it's out of my arena and the attending has to take it in his hands. If they tell me, 'well then call this person or call them again and say,' **that** annoys me. So I guess the foot work is when I'm told **you** will call so ands so and say such and such a thing. "Well pick up the phone and do it yourself." ...I feel like a secretary; it makes me feel like I have less value. ...And it doesn't challenge me to move beyond or that I'm in a relationship where I feel that what I have to say or what I have to offer is important or valued.

ACNPs argue that "the biggest determinant of whether or not they are going to be successful is the physicians they're going to work with." As one ACNP so notably declared, "those ACNPs who have been assigned to work with lousy physicians with bad attitudes are struggling before they even step foot in the door." ACNPs "who are just thrown out there to the wolves," or "left out there just hanging in the wind to make diagnoses and clinical decisions on their own be they right or wrong," often come to "see themselves as working *for* their physician rather than *with* them," "seeing themselves as physician extenders." Unfortunately, some ACNPs are unable to stay afloat. Under these circumstances, some ACNPs experience depression, which results in the need to take a leave of absence early on in this role. Therefore, establishing an open dialogue and a rapport with the staff physicians in their practice as quickly as possible is essential to their well-being while they live through the turbulence of *being adrift*. Being aligned with the staff physician(s) is one means by which ACNPs create a safety line and they work hard to develop and maintain this alignment. Alignment helps them to manage the level of complexity in their clinical practice that they do not yet know how to manage and gives them the sense of the possible, that is, a sense of hope that they can *stay afloat*.

The safety line emerges as a belief that "the physician will always be there," "recognizing their limitations," helping them "to navigate through all the trials and tribulations" of the clinical management of the patient. It is experienced as a feeling that "you're never really on your own," a sense of the physician "being present" to provide "reassurance," or a "sense of security" that "you will do the right thing," and "that you're providing the best standard of care." Physician presence as a safety line, either through "being *there*" physically or "being *with*" them by "making room for dialog," conveys to the ACNPs that they have not been abandoned, particularly during this time of *being disconnected*. In the face of uncertainty and the subsequent state of anxiety that emerges, ACNPs must turn externally to make that which is in doubt certain, or at least less uncertain.

The physicians' presence as a safety line concerns both their availability as helper and attention to the ACNPs' needs in becoming knowledgeable and skillful in the clinical management of the patients. Their presence is demonstrated in their willingness to share information, teach, coach, and demonstrate what needs to be done. These actions convey a willingness to nurture the ACNPs' professional growth and development in the direct clinical practice dimension of their role. As a result of *being uncertain*, the ACNP sees in the physician the possibility of help, comfort, and support. Lacking confidence in their abilities to clinically care for the patients safely, ACNPs need their fears and concerns dispelled in almost every new situation. In so doing, they can still hold true to the promise of keeping their patients and self safe from danger. Their opinions or impressions need to be confirmed as right and it is through this affirmation that they are able to manage *being uncertain*. Although ACNPs realize that they must eventually make decisions independently, the safety line feels most secure when they believe that they "will not be penalized if they can't make a decision." They know instead that they can "check in" or "run something by" their staff physicians anytime they have questions or concerns. As a result of physician presence, the safety line is established as a belief that the physician can be trusted to work with the ACNP to do for the patient what is both right and good. The trusting relationship prevents their fears and worries from becoming paralyzing, thus allowing ACNPs to test their own abilities and to eventually risk carrying the independence they seek. In other words, the presence of the safety line is like a ray from the beacon of light on the horizon, which enables them to envision future possibilities and encourages them to continue their struggle to *stay afloat*.

> They were wonderfully supportive. They never showed that they were irritated with how long it was taking me to come up to speed.
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> You're never on your own though. You always have physician backup; there's always someone you can work this through with.

> When you're first doing the role and carrying the responsibility you need to have a system in place for support. You need to have physicians who don't mind you popping in, maybe even several times a day to say, "I just want to run this by you, what do you think about this? Is that right?" And you know they'll confirm it or they'll say, "Yeah, that's right ninety percent of the time except in this, you know." ... Or I'll go back and say what do you think I could've done differently? You know, one of the physicians is very good at that, very supportive. And so they have taught me a lot and they're willing to do teaching with me in sessions, that type of thing, to help me with some of that decision-making. I remember I went to him once and I said, "I don't know what else to do. This is the problem. I've done this. I've done this. I've done this. I did this and it's still not fixed. What else can I do?" And he looked at me and he said, "Witchcraft."[laughs] Like there's nothing else that could have been done, you know. So just that reinforcement from him that no, there's nothing else here to the situation; you've done it and we need to look at something else because they're just gonna have to live with it; it's never going to go away.

The length and tautness of the safety line is always in a state of transition and mutual negotiation in the ACNP-physician relationship. While some ACNPs have the expectation that the physician will supervise them until they are "really sure that they are comfortable with what is going on," others desire the freedom to take risks without "the physician standing over them." But in either case, they are "grateful" and "feel lucky" or "fortunate" when their physician colleagues understand what they need, "are there to support" them as necessary, and then are willing to let them become independent through a "gradual weaning" process, all the while being willing to be available whenever their assistance is required. The safety line becomes a permanent but invisible cord that serves as a "fall back position" whenever they feel they need help.

> When you first start, I mean they would always be with me; and they used to come with me whenever I was doing something new, because they also needed to be able to see that you can do it.
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> And you always have the lifeline of the phone there, so you phone them with what you see and what you think the problem is and then you talk to them over the telephone.
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> And ... this biweekly meeting with my consultants is something that I've created to get my questions answered and if it's urgent then there's a resident on call or I'll even call my staff consultant ... And just being clear, as all nurses have to be, that either I just want to chat with them to get their reassurance and not they can stay at their desk or 'No you need to see this patient.'

There is a clear understanding and appreciation that the safety line that is available to the ACNPs in the acute care context is different from that available to NPs working in primary care. Some ACNPs "feel more protected in the hospital because if they are ever not sure, they've always got somebody to call." Noting that their patient populations can "be wide, so wide," with "diseases that you see only once in awhile," and "rare stuff that isn't straight forward," some ACNPs admit that they would "feel uncomfortable to have full autonomy." The Canadian Public Hospitals Act legislates that the final authority for this lies with the admitting physician. Therefore, there is a sense of security in the knowledge that they do not carry the "ultimate responsibility and authority" for the clinical management of the patient. Yet a tension arises as a result of their living with the paradox of searching for independence and more control all the while holding on to the comfort of the security of the physician's presence.

> Because I chose to go into the NP practice I can't say no that I don't want more independence that comes with working evenings and weekends when the attending isn't physically present, …and that's something that I would like to do for sure, but it would be a big step. Right now I have a huge buoy holding me up and that would mean swimming on my own, and that would almost be like starting over again. Just the thought of that is quite scary actually. Although it's something that would be nice, I think it would need to be done in steps because that's not where we've been at all. This is very comfortable right now. There's **always** somebody to back you up. There's **always** somebody there that you can rely on. If we go to full licensure and I cover nights and weekends and whatever, that's a whole different ball game.
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> I still don't have that confidence to be in practice on my own. Part of the reason I choose acute care is because I liked to have that network of medical people behind me who can come forward when I know I'm over my head with something or about to get over my head.
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> I mean I guess the good thing is that in the position, I'm not solely responsible for everything that goes on for all the patients. And so I think that having support both from a medical perspective as well as a nursing perspective is very important. …Like it's never that it's just me, which is different from a lot of nurse practitioners who work in various primary care settings, you know, where they're the only one and that's why they're there kind of thing. So I know if things ever get really scary or really spiraling down hill fast, that there's help on the way. …And I mean obviously things go up the ladder as far as how we practice, and so the bedside nurse is responsible, and then me, and then the attending. So there's always an hierarchy of how things go. And I'm very quick to rely on others if I'm not sure that I can handle the situation. You know I don't have a big ego that I just have to do it all myself. So it really is very comforting to know that you have that kind of set up.

Ironically, this knowledge becomes even more significant when ACNPs do not trust the staff physician(s) with whom they are partnered. Doubtful that the physician will back them up if a mistake is made, they contain their scope of practice to that which they feel they can manage without any risk, frequently defaulting back to the physician.

> But ultimately if you want to err on the side of safety and call someone about everything you can. So I'm still off the hook in a way, 'cause I always have someone that I can refer to as well.

In these situations, the strength of the safety line - its ability to enable nurses to engage in their work and to learn to take the risks necessary to become more independent – is also its danger. The safety line becomes a cord that ties them to the medical team in a dependent and disabling manner when fear of loss of their approval and the need for their affirmation becomes more important than the goals for which they strive.

The paradox inherent in the presence of the safety line is that while nurses are searching for more independence and control in their practice through being ACNPs, they also acknowledge the need and desire for the control that is retained by the physicians. Not knowing "how safe NPs really are in terms of liability" given that precedents have yet to be tested in court with NPs as part of a lawsuit, there is a sense of "walking a fine line", of "being in a no-man's land" that necessitates the belief in this backup system. Although for some ACNPs this inability to carry the full responsibility will at times become a source of frustration and limitation, they are grateful for its presence during those times when the situations they are facing are outside their scope of practice.

> I think I feel more protected in the hospital because if I ever am not sure I've got somebody to call. I mean even if there's not always a resident, there's always a fellow or a surgeon that I can double check with. …So if I were working out in the community or way up north and you're the only one there, it's either sink or swim. But I think that would be a really valuable experience too. I'd love to go to the North, to be there for three months just to sink or swim, just to know that it's me, me and me. And I know I'd do fine, but I don't have that person to call at a drop of a hat to say, you know, "I've got this child and I'm just not sure and what do you recommend?" In the hospital you don't have that because there is always somebody to call. So I'd say the fear is less when you work in the hospital because you're not alone. You're working in a team. However, you don't have the ultimate authority to make decisions like the physicians do.

Creating a safety line through an alignment with their physician colleagues not only expands the scope of the ACNPs' influence on their world within nursing, but also gives them new and different understandings about those with whom they now engage in some shared activities. Along with feeling "privileged" to develop a personal relationship with staff physicians "in a way that [they] really know each other better," ACNPs also undergo a growing awareness of and appreciation for some of the experiences that residents live through on their journeys to becoming independent medical practitioners.

> I think a lot of residents are scared. Some of them will voice it right out but not many because it's not very doctor-like. And it's interesting actually and I think that's one way that I'm privileged. I think a lot of them when you see them on the unit wouldn't appear that way. But some of the residents, they'll be asking me, "Do you think I did this right? Do you think that's right? Do you think that's correct?" And I think that's because they understand how scary it is. I think some feel very unsure of themselves and have this 'I'm so scared but will not show it ' attitude. And I don't think that people could see it that I'm scared and unsure of myself. And I think a lot of them might not show it, but it doesn't mean that they're not living it. But a lot of them will express it to me.

As a result, ACNPs begin to rethink their own experiences and their own way of engaging in and contributing to the practices of their communities as an ACNP. Perhaps it is in this growing understanding that ACNPs do not feel quite as isolated in their experiences; rather there is a sense of connectedness with others who struggle as they do, others who are also attempting to survive in their quest for a viable identity, albeit a different one. In spite of the curriculum, discipline, and exhortation, the learning that is most personally transformative for ACNPs turns out to be the learning that involves membership in these various communities of practice, where there is a sense of shared lived experience that has the ability to amplify their sense of the possible. A relationship constituted in specific shared experiences makes it possible for ACNPs to consider a new mode of belonging to this community of practice, which then galvanizes their energy in ways that creates and secures a different community of practice. This then opens up new ways of seeing themselves as ACNPs that can ultimately even reconstruct their experiences of power and identity of competence. Perhaps this is what Goethe[18] meant when he wrote: "To know someone here or there with whom you can feel there is understanding in spite of distances or thoughts unexpressed – that can make life a garden."

ACNPs quickly learn that the safety line becomes even stronger through the creation of team solidarity. Drawing from their nursing foundations, they turn towards the belief that clinical decisions need to be "spread out over a number of people" through the formation of partnerships rather than being made in isolation. Nurses, staff physicians and consultants, social workers, physiotherapists, dieticians, pharmacists, respiratory therapists, and others, including the patient and family, are seen as "friends" whose input must be taken into account in the decision-making process. In so doing, there is a sense of relief that treatment plans are "on the right track" and "blatant mistakes" will be picked up by others before they are made.

> And if you looked and were willing to ask, there was always someone around to discuss your plan of care with, or working out the math around a medication, so the pharmacist to support you in terms of showing you how to do it, and insuring that you had the right numbers down, the nutritionist to help with fluid management, and the respiratory therapists for the ventilator modes or settings.
>
> I often also rely on my nursing colleagues I must say. When I order things I will tell the nurse I ordered this thing, this amount, and if it's something that's quite unusual I will often double check with the nurse and tell them well this is where I took the information. I ordered magnesium not so long ago. Magnesium is not something we give very often here, so I got my information, got my protocol, ordered it with the protocol, and then I went to the nurse and said, "Well look, this is what I'm ordering for this patient; I used this protocol; Is this the way you understand it? Does this order make sense to you?" ...Of course I then have to rely that the nurse has experience. Some nurses I could ask them and they wouldn't know.

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[18] This quotation is Goethe's *Wilhelm Meister's Apprenticeship* [1786-1830], *bk., VII, ch. 5.* Bartlett, J. & Kaplan, J. (Eds.). (1992). *Barlett's familiar quotations* (16th ed.). New York: Little, Brown and Company.

> And often if I think that the nurse that I'm asking to do something doesn't have the experience or knowledge to know that, I will ask the charge nurse, "Would you help so and so. This is what I've ordered; do you understand the order? Can you carry it through and does that make sense?" So I think that's one way that I can help myself not be constantly worried. So I think my nursing colleague is a good safe guard for me. That's why I'm attached to them [said softly in respectful tone].

As importantly, at this time of *being disconnected*, striving together becomes an important enterprise (Wenger, 1998), not only as a mechanism to prevent mistakes, but also as part of their larger quest for a viable identity. ACNPs must find ways to organize their lives with their immediate colleagues and patients to learn what it is they need to do. In doing so, they develop or preserve a sense of themselves that they can live with and have some inkling of belonging, all the while learning to fulfill the requirements of their employers and patients. As a point of illustration, ACNPs quickly find that they need to cultivate respect with the nurses by being effective and efficient right from day one, even though they lack the requisite knowledge and skill to be able to do this in their new role. Thus, ACNPs purposely strive to create opportunities to make and maintain connections with their nursing colleagues in their practice, stressing the importance of earning their respect, which takes a great deal of time and effort. Some do so by attending nursing handover rounds, appreciating that the areas of concern for nursing are of significance to the plan of care, as well as the fact that the depth of information they have about their patients is usually much greater than what the resident has to offer. In addition, they enjoy the social camaraderie that takes place during this event. Others make "conscious efforts to be part of the nursing team" by negotiating "the time that is going to work best" for them to undertake the procedures required by the patients. Some ensure that they remain involved in traditional nursing activities, such as suctioning the patient, emptying bedpans, or reprogramming intravenous pumps as the need arises, demonstrating that they want to "work side by side with nurses, not above them," just as they wish to "work side by side with the physician, not below them." Some ACNPs invite the nurses to participate in the writing of the orders by purposely creating opportunities for their input, thus ensuring that their concerns are heard, respect for their ideas demonstrated in a way that empowers them, the safety net strengthened, and the relationship with nurses solidified in a new type of partnership. This is best reflected in the following passage.

> It's not easy to flip over to writing on the physician's order sheets and then directing your colleagues in terms of giving them orders as well. ...But you develop techniques of how to get around that. Yes, there's specific directions from a litigation and liability perspective that need to be written on the physician order sheet and most of those directives are medical

> directives, but others of them are inviting the nurse to be part of the decision making and order writing as well, not just being a scribe. ... So, these orders have to be written, and in terms of inviting the nurse to, okay – "Well what do you think of the plan? We've had this team discussion so let's summarize and I'll write these orders on the physician order sheet. So NPO, the IV solution, the TFI. How does this look to you? We've calculated out that the TFI's going to be about 8 mls per kilo per hour. What does that mean to you? How many mls per hour?" And getting the bedside nurses to participate in my writing the orders and having them check them – "Does this look okay to you? Is this what we talked about?" Confirming it, that I have heard, the nurse has understood, and this is exactly what the physician and the team has planned out for this patient. So I'll sign the bottom and then the nurse processes the orders. But again, it's all about team work and communication. And I'm not telling [stated it like a directive] the nurse what to do in so many words. I mean these are medical orders, but we have to work together and they've had their input on how they are going to look; I'm just putting them down in black and white.

Despite living in a time of *being adrift*, a turbulent time during which they experience *being disconnected* from that which is familiar and feels like home, a time of *being uncertain* and *lost*, the work of *staying afloat* allows ACNPs to also experience moments of undeniable joy and satisfaction. They are enabled to experience moments, however fleeting, of awe and wonder at the things they do and accomplish. It is these moments that provide them with a glimpse of what the future holds, the possibility of finding the perfect fit somewhere on the horizon.

CHAPTER SIX

BEING AN ACUTE CARE NURSE PRACTITIONER

> I remember the first time I felt like a real nurse practitioner was my first night solo with a real critically ill infant and getting through all of the trials and tribulations and then thinking that I made it through the night. It was the baby that the transport team had brought in from a local hospital, a big beautiful term baby girl, Irish family. The mother had just given birth and she was right at this baby's bedside. And we were loosing her big time. We knew that this baby was extremely septic and we were suspecting that this infant could be strep sepsis, overwhelming sepsis. And we had lost some ground on that time delay before it was recognized that this baby was deteriorating; and when they deteriorate, they deteriorate rapidly. So it was just working with the family. And the mother and the dad were at the bedside holding this baby's hand and we're intubating and putting in lines and trying to answer their questions. But they're not in your face. They're just there supporting their daughter and being there and fully trusting the medical and nursing team, you know. It was incredible as we worked together. And at the beginning it was mostly the skills - so I was able to do the intubation with the RT. We got the drugs drawn up, got them ordered, we got them figured out. We knew this was a sick baby coming, so I worked with the respiratory therapist who was in-house, the attending physician, and two of the nurses in the unit that were going to be the admission nurses and we had everything ready. I had all the orders done, we had all our calculations, we had all our pumps all lined up and labeled. And so it was going to be as efficient an admission as we could possibly have or that we could have control over. There's always the patient that makes the variable [laughs] but, as much as we could control, we were there. So getting the airway efficiently, getting the lines in and pushing fluids, and getting the orders, and managing a cardiac arrest, and so those kinds of critical things, the technical part of it, and the sense of accomplishment with having that expertise of being able to do those skills. We all worked together in a true sense; the doc was there, there were three bedside nurses, there were people mixing drugs at the bedside, at the counter, and everything went so well. But being able to be successful, being able to facilitate such a critically ill infant through admission and stabilization and the family as well. I mean, it's tough being able to do that with the parents in the room. ... I don't think you ever get really comfortable with it, but the fact is, is that they need to be there. So it's having their trust and their confidence in that you are doing your best that you can for this baby. So it was good. But then to have the Attending's [physician's] confidence that I could manage this type of patient also was a professional [pause] compliment I guess. But, it wasn't about me. It was a team effort. I mean I had a great team to work with as well. It's infectious; it was calm and there was a sense of togetherness for sure. And the rewarding thing is that the little girl did turn around and did get better and went home seven days later. But it was that sense of working together and everyone - nurse, doctor, parents - were right there, and encouraging each other, and I'm sure there was a little bit of praying going on as well. But it was a real sense of togetherness. And, I mean the outcome isn't always as good as it was in this particular one, but there was a real sense of success and accomplishment and we did make a difference in this family's and this baby's lives. And it took all of us; it wasn't just one person doing everything. I think that had to be one of the most rewarding parts, knowing I was a key player in that team dynamic.

For ACNPs, *being an ACNP* means "feeling like an ACNP" and occurs as a result of being able "to do" direct clinical practice. Hegel (1807/1971) related that it is in "the doing" that we inevitability find ourselves, and extend ourselves, and that what we produce defines us and gives us form. José Saramago (2000/2002), winner of the Nobel Prize for Literature, in his book *The Cave*, tells of the story of an aging potter named Cipriano Algor who unwillingly gives up his craft and is impelled to adapt by making hundreds of ceramic figurines. Through the telling of this allegorical story, which draws on the philosophies of Aristotle, Plato, Hegel, and Heidegger, Saramago reveals that Cipriano recognizes himself in the shaping of a pot on a potter's wheel. The pot and the potter serve as central cultural metaphors for the dialectic of consciousness and the material world. Similarly, this introductory passage demonstrates that b*eing an ACNP* is a complex process that combines doing, talking, thinking, feeling, and belonging to a clinical practice team that recognizes, acknowledges, and values designated nurses performing clinical components of practice traditionally carried out by physicians.

Over time, ACNPs gradually become more skilled in clinically managing patients with the new knowledge and skills they acquire experientially, as learned with the help of, and despite any hindrance from, members in their social communities. Opportunities to care for patients with similar health care problems facilitate the solidification and refinement of previously learned knowledge, along with the continuing acquisition of new knowledge. ACNPs[19] may journey two or three years, sometimes even more, with an intense focus and dedication of time in the same clinical practice specialty, encountering the same type of practice issues, working with the same medical and nursing team, before they perceive themselves as having confidence in their competence, as well as being comfortable in direct clinical practice. Yet, *being competent, confident, and comfortable* clinically in direct clinical practice are the performance markers that need to be recognized by both self and others before ACNPs can successfully journey through the turbulence experienced in *Being Adrift*.

Being competent, *confident*, and *comfortable* in the performance of the various elements of their direct clinical practice opens the way for ACNPs to negotiate a way of *being committed and connected* to their patients and families and members of their community of practice in a manner that is more morally acceptable to them. The complex combination of these mutually constitutive elements makes it possible for ACNPs to discover being more and with this a sense of satisfaction and the lived experience of *being content*. Moreover, as a result of experiencing clinical practice in this new way, it is now possible for ACNPs to shift their dialectical perspective. There is a gradual movement away from the internal polarized discourse and struggle (i.e., am I a physician replacement *or* a nurse *or* neither?), which occurs through the time of *Being*

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[19] The time frame may be reduced for ACNPs who have been neonatal transport nurses or CNSs in the same specialty service working with the same team prior to becoming ACNPs, but this is not always so.

Adrift, to the emergence of a acknowledgement that harmony can exist within previously perceived opposites and that a new identity can arise from patterns of practice that were once antagonistic. This does not infer that tensions, conflicts, or concessions no longer exist. Rather, ACNPs now begin to acknowledge that what they "do" in their practice with that which has been drawn from the medical model of care enhances what they "do" with that which has been drawn from their nursing world. This perspective is very different from positing a dichotomy with a fundamental divergence between them. Consequently, ACNPs gradually experience a transformation in their lived identity, an identity, which Charles Taylor (1985a, 1989) reminds us, is shaped by recognition, misrecognition, or its absence, and which crucially depends on dialogical relations with others.

It is essential to remember that there is a profound connection between identity and practice (Wenger, 1998). "Developing a practice requires the formation of a community whose members can engage with one another and thus acknowledge each other as participants. As a consequence, practice entails the negotiation of ways of being a person in that context" (p. 149). In the course of engaging in clinical practice - which is negotiated in the course of doing the clinical practice work and interacting with others (albeit within their own unique experiences) - ACNPs understand what they do, what they know, don't know and don't want to know, and how they interpret their position within the community in which they practice. They find themselves at a time and place in their journey where they are comfortable and confident with who they are; what they do; what they understand about their relationship with physicians, staff nurses, patients, and families; and the articulation of this to others. As one ACNP expressed, "I think I spend more time with families now saying – this is who I am, this is what I can do for you, this is what our relationship will look like if that's okay with you." They experience a sense of excitement and joy in their abilities and accomplishments, of meeting the challenges of their clinical practice. These feelings combined with a sense of belonging, of being more, and of being able to make a difference begin to prevail. As a result, ACNPs identify themselves as *being ACNPs*, and some are able to find the "perfect fit."

Before exploring further the various threads associated with *being an ACNP*, that is, *being competent, confident, comfortable, and committed, connected, and content*, the mutually constitutive and iterative nature of these core elements of *being an ACNP* needs to be emphasized. For instance, although the threads of *being competent*, *confident*, and *comfortable* will be examined separately, each one is so integral to the others that it is nearly impossible at times to distinguish between their separate natures.

Generally speaking, is it not common for all of us to use these three words interchangeably in our day to day speech? Similarly, it is not unusual to hear ACNPs speak of feeling confident and comfortable in carving out a scope of practice in which they feel competent to practice autonomously, yet at other times, they express a lack of confidence in their own abilities despite acknowledging that others deem them competent. Nonetheless, the differences, the similarities, and their connectedness to each other are brought into the open for better understanding.

Being Competent

Competence, a word derived from the Latin word *competere*, - *com* meaning 'together with' and *petere* meaning to 'aim at' – is defined by the Oxford English Dictionary (Trumble & Stevenson, 2002) as having a sufficient or adequate degree of knowledge and skill to do a task effectively and safely. *Being competent* necessarily moves the ACNP beyond taking on the label "ACNP" to the realm of doing what ACNPs do, being treated as competent, forming a community of practice that permits mutual engagement in the work set forth to be accomplished, and entertaining certain relations with other communities of practice. In this process, ACNPs find a personal meaning to the label "ACNP." As Wenger (1998) reminded us, when we handle ourselves competently, experience competence, and are recognized as competent, we begin to feel that we are a full member of the community of practice in which we are engaged (p. 152). We feel we are in familiar territory. These dimensions of competence then become dimensions of our identity. In this sense, identity is an experience and a display of competence. Consequently, knowledge and skill must be transformed into action. Knowing must become doing. This is what Benner (1984), Benner, Hooper-Kyriakidis, and Stannard (1999) and Schön (1983, 1987) have referred to as the act of transforming "knowing that" into 'knowing how", also referred to as the acquisition of *knowing-in-action.* More simply stated, ACNPs need to be considered by self and others to be fit or suitably and sufficiently qualified to independently carry out ("do") the task of "medically" managing the patients within their specialty of practice in the acute care setting.

In the truer sense of the meaning of the word *competere,* the ACNP, the physician(s), the nurses, and even the patients strive together to bring the ACNPs to their rightful place within the larger community of clinical practice. Borrowing from the Latin word *competentia*, *being competent* necessitates that there exist an inherent sense of agreement and a meeting of the minds (Barnhart, 1988). B*eing competent* then is formed within a context of mutual engagement, and is an outcome of a joint enterprise with members of the community of practice in which there is a shared or mutually negotiated range of expectations for performance. Being engaged in action with other people in the performance of clinical care activities means that all members of the community must come to some understanding - even if it is not articulated - about what being competent as an ACNP means. Others (most notably the ACNPs' physician partner(s) and the nursing staff with whom they work, and then ultimately the patient and family), must recognize and acknowledge ACNP competence in the ACNPs' performances. ACNPs subsequently must experience themselves as competent as observed in the recognition by the other(s) in combination with their own experience of appreciation of others' performances of similar activities as compared to their own performance and capableness as self-observed. More simply but eloquently stated, "We are because we are seen" (Rilke, 1996).

If, as illustrated in this chapter's introductory passage, ACNPs are given space by physicians to independently initiate a treatment plan, their engagement in practice brings into everyone's awareness the autonomous nature of their position for medical decision-making, which is both bestowed and expected in being competent as an ACNP. In contrast, for those ACNPs engaged in a practice that requires them to seek out a verbal or written order by a resident or staff physician for all medical interventions, *being competent* is more difficult to discern, particularly when the humble and powerless status of the ACNPs' practice is the most striking focus. In both cases, however, the meaning of *being competent* is experienced as a consequence of participation in their community of practice and their identity as ACNPs is being constructed accordingly. But where does recognition of competence begin? How does it evolve?

Being competent must first be initiated with the endowment of both the legal authority and the qualifications to grant admissibility into the medical sphere, even if it only means being on the periphery of that world. Access to the knowledge and skills that helps bring about competence in that world initially occurs at school. Graduation from a legitimately recognized education program authorizes ACNPs, administrators of the employing institutions, and physicians with whom they are partnered, to publicly claim that the ACNPs hold an officially recognized position and are qualified by their convincing demonstrations of "special" attributes, skills, and knowledge to intercede in the matters of disease and death traditionally held by medicine alone. Those provinces that have a licensed status for the ACNP add a further symbol of recognition of ACNP competence by investing an official social status through a bureaucratic enterprise. As noted by Haas and Shaffir (1987), these official sanctions bring about a "professed authority" that demands its workers "project an image of trustworthy competence to their clients" (p. 1).

Yet, carrying the certification and/or licensure does not automatically result in ACNPs' having the ability to handle themselves competently or to experience competence. *Being competent* only develops with experience and the recognition that theoretical knowledge has been translated into an acceptable form of action in the clinical setting in the autonomous manner that was intended. Still, those ACNPs who have enacted the ACNP role within the confines of their particular institution as a result of specialized in-house or "home grown" training programs, or those who have "performed the role" while simultaneously attending school, experience feelings of illegitimacy that stems from their inability to claim or possess "real" role validity. These feelings are not ameliorated until they have made the status passage that transpires upon graduation from a legitimating institution (i.e., a professional school as part of a scientifically based university program) and subsequently become invested with the appropriate professional knowledge and certification.

This need to feel like a "real" NP is well articulated by one participant who shared her story of having pioneered the role of the ACNP in her institution. At the outset of the role, university-based ACNP programs were not readily available in Canada and family and financial commitments prevented her from leaving home to attend school for an extended period of time. Instead, she trained within an institution-based educational program specific to her subspecialty (quite a common phenomenon in Canada during the 1980s and early 1990s). She had lived the clinical practice component of this expanded nursing role for several years before attaining a master's degree with an ACNP certificate (at which time her title changed to NP). When asked to describe the first time she had felt like a nurse practitioner, she prefaced her particular story of a clinical situation in which she had been involved with the following query expressed with a laugh and a tentative intonation: "A real nurse practitioner?" The following is the passage that explores her reflections on feeling "real."

> ACNP: I had only two courses left to actually get my official NP certificate, so I had been working as an advanced nurse for almost four years. And so, ya, hmmm. Interesting. [quietly and reflective tone] [long pause]
>
> INT: You put the word "real" in front. What do you mean by that? [She laughs.]

> ACNP: I guess with the word [real] and the actual credentials – isn't that funny [reflective tone] because when you asked me to relate back to that particular time [I felt like an NP] and that incident it was pre-graduation of my NP. Hmmm [softly – she has turned her head and looked out the window as if reflecting on why she had used that word.] Interesting. [long pause] ... I guess I found that in that role I wasn't really valued outside the hospital and realized the limitations of a home-grown program versus a program that had a certification process attached to it and the credentialing, portability. ...And you start reading all the journals and the articles and meeting people that **are** nurse practitioners, that are bonafied nurse practitioners, you know, official, credentialed nurse practitioners and theirs just seemed so much better and they got the recognition and they had the credentials, and the portability seemed huge and I never thought it would but it did, and so then I started to look at how can I get like that too.

This example illustrates the complexity of *being competent* and the need to understand it as a progression in which the ACNP is forced to give a convincing and correct performance in a role that has a specific privileged and reputed status bestowed upon it. Recognition in this symbolic form affirms the new role and ACNPs' identity and helps to sustain it.

Further understanding as to why having the official authorization does not inevitably bring about competence is engendered when there is an appreciation for the fact that ACNPs constantly measure their understandings and insights against the lived reality of their concrete experiences, which of course are always more complex than any particular interpretation can portray. Consequently, the recognition accorded to the ACNPs by the occupational groups with whom they work, especially the physicians and the nursing staff, becomes just as important as the symbolic legitimization. There is an unspoken, taken-for-granted sense of what competence looks like from the other's point of view and it quickly seeps into the ACNPs' expectations of themselves.

> Well from the nurses' point of view, I mean you're expected to be competent in the skills that they want you to do. You should be able to get IVs when nobody else can [laughs]. So you do these procedures with the expectation that you're going to get them and that you'll be competent in the extra skills, and that they can go to you for a decision and get a decision.

Well-known author Dale Carnegie (1936/1964) said there are four ways in which we have contact with the world and are classified and evaluated by others. It all comes down to "what we do, how we look, what we say and how we say it." Consequently, in order to be recognized as competent to take on the clinical decisions traditionally held by the physician, the ACNP must learn to act the medical professional role. This involves projecting the idea of control and objectivity or impersonality that is so inherent in the medical profession. This projection is necessarily accomplished through a process of mystification, what Haas and Shaffir (1987) have termed a "special or transcendental authority" (p. 2). Mystification results from the use of certain symbols or rituals, such as abstruse language, which serves to reinforce the special and privileged status of those specially prepared to participate in their world. One such symbol of competence is speaking like a physician. Learning to speak the language and to present the script in the appropriate demeanor both affirms the new role and helps others recognize the ACNPs' competence. Returning to a passage previously presented in *Being Lost*, the following participant's remarks indicate the importance of the appearance of competence, as she describes her impression of an ACNP with whom she had worked as a staff nurse prior to becoming an ACNP herself.

> She seems to know everything. ... So the way she carries herself - the short no nonsense hair style, no makeup, tanned - she just, she has a presence about her.... And I remember when she started and she'd go through the list - GSW, GSW, GSW - and I'm like, "Oh my word, this is like ER."... So her presence, her way of carrying herself and speaking, it was a lot of acronyms and you just got the sense she was competent... I just knew she was a nurse who knew God more than I'd ever know, and seemed as knowledgeable as a physician and worked in a field that boggles my mind, but she's able to pull it all together.

Lewis Carroll (1865/1971) whimsically wrote of this display of abstruse language used by others to create an aura of having a privileged and authoritative position in *Alice's Adventures in Wonderland*. When a group of curious birds and animals, along with Alice, manage to swim ashore from having somehow fallen into the Pool of Tears, Mouse, the person with the authority among them, is given the responsibility of solving the issue of how to get the party members dry so they will not catch a bad cold. Mouse instructs them all to sit down in a large ring and, with himself in the middle, engages in the following narrative:

> 'Ahem!' said the Mouse with an important air. 'Are you all ready? This is the driest thing I know. Silence all round, if you please! "William the Conqueror, whose cause was favoured by the pope, was soon submitted to by the English, who wanted leaders, and had been of late much accustomed to usurpation and conquest. Edwin and Morcare, the earls of Mercia and Northumbria-------"
>
> 'Ugh!' said the Lory, with a shiver.
>
> 'I beg your pardon!' said the Mouse, frowning, but very politely. 'Did you speak?'
>
> 'Not I!' said the Lory, hastily.
>
> 'I thought you did,' said the Mouse. 'I proceed. "Edwin and Morcar, the earls of Mercia and Northumbria, declared for him; and even Stigand, the patriotic archbishop of Canterbury, found it advisable ....to go with Edgar Atheling to meet William and offer him the crown. William's conduct at first was moderate. But the insolence of his Normans-------." How are you getting on now, my dear?' it continued, turning to Alice as it spoke.
>
> 'As wet as ever,' said Alice in a melancholy tone: 'it doesn't seem to dry me at all.' (p. 25)

Although the party understands nothing of what has been said, and the intervention of telling such a dry story fails to get them dry, the members are more willing to accept this remedy from one whose language and aura convince them of his competence to do so. When the Dodo moves to adjourn the meeting for the immediate adoption of "more energetic remedies" to get them dry, the Eaglet challenges the Dodo's understanding of long words. This results in the party's audible tittering. In other words, the Dodo is not immediately recognized as competent to solve the problem and is ultimately tested.

ACNPs readily acknowledge that learning to speak in telegraphic sentences and being able to look the physician in the eye when defending their treatment choices helps them to validate to others that they are competent and thus can be trusted to make the decisions correctly. As one ACNP noted, "Without appropriate verbalization, how else would others know what you're thinking? Thinking can't be seen." Because the role is a moral one, it requires a drama in which players construct convincing performances of their special role. Audiences, such as those that are present during the traditional daily medical rounds, legitimate this performance, which promotes ACNP confidence in his/her own competence, and ultimately helps to shape the ACNP's identity and conception of self. In short, the ritual of speaking or writing like a physician, affects both spectators (health care team members, patients, families) and the ACNPs. In brief then, learning to think like a physician reveals itself in how the ACNPs script their thoughts. As one ACNP disclosed, ACNPs are perceived as competent when they "speak strictly in problem-based terms, provide a running differential, place the information into slots, identify the ways in which those problems can best be fixed, and then prioritize them based on the whole big picture."

Similarly, competence is revealed in the written language and form in the physician's progress notes and discharge summaries, two other privileged medical rituals. As one ACNP shared:

> Initially my histories were like two pages long, and – "No, no, no. You've got to condense, condense, condense." And ...I got to the point where I could do a history in half a page from two pages. And the difference was learning that when you're talking to physicians, learning to communicate what **they** [emphasized] want to know, and in that way you communicate that you understand what's important to them. It doesn't mean that you ignore the other things; you just don't bore them with those details because that's not what they're interested in. So for example, a physician doesn't want to know about the patient's psychosocial background... if it doesn't have relevance to the procedure that they're going to perform or the patient's risk. They want to know the patient's physiologic status as it relates to what they want to know. ... So they want a very targeted, very brief, they want to know about their patients in short form. They don't want to be standing there for fifteen minutes while you tell them everything there is to know about this patient because that's not what they're interested in. That's important information but they don't want to hear it.

> So what I learned was that you just have to speak **their** [emphasized] language. …When you write the notes you just write them in a way that is relevant to them, that they're going to read.

Until then, I had felt as if
I had been born into a
raging ocean where I swam
relentlessly, flailing my arms
in hope of rescue, of reaching
a shoreline I never sighted.
But when at last I wrote
my first words, I felt an
island rising beneath my
feet like the back of a
whole. I was no longer
captive. Through language
I was free.

~ Baca,1990 ~

27-year-old female, white, married, Grav 0/Para 0, Ab 0. Presents with burning on voiding, vaginal itching, and discharge x 4 days.

3 weeks PTA: treated by family physician for bronchitis with erythromycin. Improved within 5 days. 4 to 5 days PTA: noted burning on urination, intense vaginal itching, thick white 'smelly' discharge. Warm water douche – no relief. No previous history vaginal infection, UTI, or pelvic surgery. Monogamous sexual relationship. On low-estrogen birth control pills x 3 years with no SE.
Vulva and vagina erythematous and edematous. Thick, white, curdlike discharge on vaginal walls. Cervix pink, no lesions. Bimanual examination – no pain on palpating cervix, no enlargement of uterus or ovaries.
Specimens: pap smear, Chlamydia to lab. KOH prep shows mycelia and spores of *Candida albicans*.
Dx: Candida vaginitis

Ironically, this expectation that the ACNP speak only in a manner that reflects competence as defined by the medical profession (and subsequently accepted and expected by Western society) is gradually waved once the ACNP's trustworthiness has been established. As noted by ACNPs, once they are deemed competent, they no longer have to use the "exact" medical terminology in order to be trusted. In fact, when they are at a loss for the "right" words to describe what they are observing, they only have to acknowledge that "the patient doesn't look right" for their physician partners to respond to their requests for assistance. One participant with over a decade of experience as an ACNP summarized this need to revert to her impressions when unable to speak in "medical-eze." She knows that the physicians trust her abilities and so believe her concerns.

> So just to describe the baby's color or something. It could mean so many different things to other people, but sometimes I mean, it is just like kind of what's your impression. The baby looks like shit, but you don't mean he's brown, but, you know, he's just terrible.

In other words, colloquialisms become acceptable in certain circumstances when the ACNP is finally recognized and acknowledged as *being competent*. ACNPs acknowledge that they are the eyes and ears of the physician when they call to give them information and consequently must be able to help the physicians visualize that with which they are being confronted. This situation is best facilitated when both parties speak a language that results in the same interpretation. In point of fact, being unable to speak the language becomes an indicator for both of them that the ACNP may be outside his/her scope of practice.

> Sometimes you have to get the physician involved …say this is what I think is happening or I don't know what's happening but something's happening and these are the symptoms and this is what I think and this is what I heard when I listened to the chest or I heard something that I wasn't sure what it was, if he gets bronchial breath sounds or I just need you to have a look and see if we need to do anything about it.

Regrettably, ACNPs also acknowledge that the recognition of *being competent* with its privileges of leniency generally remains confined to the physician group and health care professionals with whom they routinely work. It is not automatically conferred by others simply because competence has been recognized and acknowledged in other publicly identified ways, such as, legitimized credentialing and being assigned night and weekend call responsibilities. Unlike the assignation of the MD title, ACNPs must continuously prove their competence to each new member of the medical team. One ACNP describes this ongoing struggle to prove her competence to the ever-changing resident groups when she is unable to speak in appropriate medical jargon. Once again, this passage demonstrates the power that "what we say and how we say it" is an essential component of the recognition of *being competent*.

> And you look at the patient and since you know them you know the patient's sick. So it's communicating that to the physicians. … Because the consultants just know if we say the patient's sick and we can't quite verbalize the exact, you know, we can't come up with the medical diagnosis, we can say I think he's in heart failure or, you know, I think he's in heart failure here because there's edema, I think I see fluid on the x-ray. We're pretty good at reading x-rays but you know, we're not physicians in diagnosing things from x-rays. So we sometimes don't have the language that I think the residents needs to hear, other than the patient's sick, he can't breath, the family can't manage him at night, he's been to Emerg, nothing's been done, I ordered this, this and this, is there anything I need to do? And, then it'll be, "No. Call me when you get all those things back." Whereas the consultant will come and see the patient, and say, "Yeah, you're right, the patient's sick. Yeah, we probably do need to admit him. Let's see what the x-ray shows."

The daily medical round is one of the main platforms where the medical script is traditionally enacted. Being able to articulate and defend one's position when placed front and center is not only the testing ground for competence, but also allows for its recognition by the health care team members, patients, and families. Recognition is subsequently validated and augmented when the physician, either verbally or through the granting of additional privileges and responsibilities, such as taking call, publicly acknowledges the ACNP's knowledge and skill. Affirmation once again helps to shape the ACNP's emerging professional identity and a changing conception of self as *being competent*.

> It's been a huge bonus for us to be recognized and valued as a collaborative member of the team. And when residents come into the unit or will be on be on rounds, the NP will often, you know, I guess be valued and respected for their input as part of the team providing the care for the patient and family that day.

Additionally, patients and families quickly come to recognize that the ACNPs can be deemed competent because they are placed at the fore as part of the time-honored drama of being tested by the physician, and, on these occasions, are heard to use the mystical language of the medical profession. In other words, these practices elevate and separate the ACNP from the traditional nursing role and align the ACNPs with that of medicine. The ACNPs' ability to demonstrate their knowledge and skill to the satisfaction of the physician(s) during these times convinces not only the physicians, but also the patients and their families that they are trustworthy to carry out the patients' clinical management at an advanced level.

> And in fact because they see us on rounds with the doctor every day they think we're doctors too, so I always make that quite clear that I'm not a doctor.

> And I guess it's because of the position that I'm in now as a nurse practitioner and she [the patient] would see me on rounds with the physician every day and I'd be there answering questions with the physician that she trusted me with that decision.

Being assigned "call duties" is another sign of the affirmation of ACNP competence. It is what Turner (1969) would call the rite of reincorporation or reintegration (post liminal) stage, the time in which the ACNP is brought back into the health care team but having taken up a new status in this new position within the team. They have been permitted to belong (even if only marginally) to a new group. Being on-call means being the first notified by any health care professional to medically address patient care issues. This may be throughout the weekday when the physician is present within the institution, or on nights and weekends, when he/she is not physically accessible. The physician is in effect publicly acknowledging to the ACNP, the institution, and the patients that they have placed their trust in the ACNPs' level of knowledge, skills, and clinical judgments. It is their affirmation that the ACNPs no longer need a physician in close proximity to safely carry out the clinical management of the patients. The ACNPs have proven that they can in fact "think like a physician."

"Thinking like a physician" ultimately refers not only to just speaking in the language of a doctor, but also to the demonstration of their competence by bringing their new knowledge to bear on practice situations where its application is problematic (Schön, 1987). ACNPs have proven in these various clinical arenas that they can start from standardized observations, physical examinations, interviews, and laboratory tests, and reason their way to plausible diagnoses of the patient's illness and a proposed strategy of treatment. This ability even extends to those situations where the problem is not initially clear and there is no obvious fit between the characteristics of the situation and the available body of theory and techniques. Affirmation of competence indicates that the ACNP has passed the initiation into the traditions of the physician's community of practitioners and the practice world they inhabit (Schön; Wenger, 1998). Competent ACNPs have demonstrated that they have learned "the community's conventions, constraints, language, and appreciative systems, their repertoire of exemplars, systematic knowledge, and patterns of knowing-in-action" (Schön, p. 36). In other words, there is enough confidence in the ACNPs' competence to let them take the ship's helm to sail autonomously, to fly solo. This acknowledgement of others' trust and confidence in their competence means that responsibility is "given over" to the ACNP and at the same time the ACNP is willing to accept and take on that responsibility. That is, the emergence of different interactive patterns, roles, and responsibilities brought about by the increasing confidence with the clinical component of their practice establishes or marks the ACNP as being vested with a "sacred" position with the team (Turner, 1969).

> [And] if you've been here for awhile they [the physicians] trust you and so they don't necessarily come in and so I was responsible for these two small babies. There's nobody else there on nights and so I got to do everything, put the lines in and make all the management decisions and things like that.

As a final point, the ACNPs learn they are competent through the positive feedback they receive from their physician colleagues. This comes in various ways, some subtle and some explicit. The words heard not only lead to feelings of being valued as ACNPs but also reinforces that how they acted or what they thought are valid and therefore strengthens a sense of *being competent*. The following participant's comments depict an open form of medical reinforcement, one which she said brought about a change in her own attitude about who she was as an ACNP by building her confidence in her own competence.

> These people [physicians] have had a lot more education than I have, and like I say, they certainly know more than I do. And I'll even go and I'll talk about our cardiac caths and that with the physician and he'll go, "Well what do you think about this? And maybe we'll do this first." And I say, "I'm just giving you information; I'm not suggesting how your medical treatment should be; I'm just sharing with you what his echo showed and what this showed." Because I almost feel like that maybe in the back of their mind they think - oh who does she think she is? And so I expressed this to him and he goes, "No," he says, "You know more about this disease in these people than I do, so you are a valid team member." So you know it's nice getting those little boosts here and there, that what you're saying is valid and valued. So that certainly shapes down the line how you're going to talk to these people and interact with them.

A more subtle, yet powerful form of positive feedback comes with the emergence of deferral to the ACNP by members of the health care team, be they the nursing staff, the physicians, and sometimes even the patients. Nurses chose to seek answers to their clinical problems from the ACNPs rather than calling upon the physician; physician colleagues initiate a direct consult to the ACNP; staff physicians inform new residents and/or their patients that they are to call upon the knowledge and skill of the ACNPs; physicians who physically distance themselves from the situation. These illustrations are all ways and means by which the ACNPs' competence is acknowledged to them and others. The following excerpts are just but a few examples of these forms of affirmation.

> And they'll [physicians] say, "Well we really want you [the ACNP] to meet this patient and family because she's going to have brain tumor surgery and we really feel it's important that you get to know them and you can help them with any problems or issues that they have.
>
> And he [the consulting physician] made the comment to me, he said: "You're as good as a doctor."
>
> And now I get a family physician on the phone who says, "I have a baby so and so out here in this little wee hospital, what do you think?" And I tell them and the plan of care seems reasonable and often times the note that comes to me comes with doctor in front of my name, even though I've identified myself as "Yes I am on call for cardiology but you are speaking with a nurse practitioner."
>
> And I would say to the patient, "Do you want to see the nephrologist today?" And they would say, "No I don't want to see the nephrologist today." And so they wouldn't. They would just see me, the NP. And I always though that was so bizarre and strange and, you know, the physicians seemed quite confident for that to happen.
>
> I was working with [patient] and doing that [peritoneal] tap and Dr. [name] had left and I was all of a sudden in charge with this drainage procedure and it's like, "Wow, this is different", because the surgeon would never have left an RN in the room with this procedure going on and not come back [laughs]. You know what I mean? Like he had trained me when to remove the tube and I was directing her changing positions so that we could optimize how much fluid we were getting out. And I would finish the procedure and I would wrap up and then she'd be gone. It's like, "yeah." I guess I would say that was the first time feeling that I was a nurse practitioner - I hadn't actually inserted that needle - but I was kind of running the show after he left.

An equally powerful form of recognition of *being competent* is the word of mouth spread within the medical colleague circle that the ACNP has the knowledge and skill necessary to care for a specialized group of patients after the ACNP has informed and/or instructed a physician in what is needed in the way of treatment plans. This recognition and acknowledgement of their competence gives a form of legitimacy to their competence and helps to further develop or reinforce the confidence that they have in themselves and that others have placed in them. For instance, an ACNP caring for a specific patient population with a relatively rare and complex disease process acknowledged that general practitioners throughout the region recognize her capabilities. They are "glad" to place the care of their patients within her hands as they so rarely see the problem in their practice. They frequently phone her directly for advice on medical management issues for these patients. Similarly, another ACNP noted that both physicians and nurses in the public health community across the province now directly consult and make referrals to her in the management and treatment of the infectious diseases subspecialty cases in which she is involved. Likewise, another shared that the staff physicians in her practice instruct the residents to consult her directly regarding pain management and sedation during invasive procedures due to her knowledge, skill, and interest in these areas. In the same way, staff physicians begin to increasingly defer to the ACNPs' acquired expertise in the procedural skills they have undertaken in their practice.

But when are ACNPs deemed fit to do the task? What does ACNP clinical competence look like in action? How does it manifest itself? How does the ACNP experience competence? How does it relate to *being confident* and *comfortable*?

Drawing from the passage offered at the outset of this chapter, *being competent* in clinical practice is demonstrated by the ACNPs' ability to initiate and make an individualized medical plan of care for the patients, independent of the physician. In any given clinical situation (within the confines of their designated scope of practice), the ACNPs not only know that there is a health care problem that needs to be addressed, but they are now able to accurately label the problems, understand their significance, identify possible solutions, articulate and defend the plan, and take responsibility for implementing the treatment plan, all with a diminishing sense of angst. This means that they have learned to put linear thinking aside. Systems thinking and the interactive nature of each of the bodily systems with each other have become second nature when figuring out pathophysiological problems. They make multiple correlations in their mind in the form of running differentials and then narrow the range of choices based on the information at hand. They are able to do this on limited information, having learned to live with the risk of developing and initiating a treatment plan of care before having all the definitive information available to them.

The location at which the ship finds itself as a result of prudent judgment only, or of data about which there is considerable uncertainty, is called the reckoning point.
~ Gabriel de Ciscar,
Curso de Estudios Elementales de Marina[20]

> You have to be able to say what's important in the maternal history with this small baby who's blue, like what facts do you need, so that you can ask for those quickly and then that can shape what the next problems are, and then you have to make one more a priority than another. So it's doing that kind of running differential in your head and putting that information into slots and kind of reorganizing what the problem is. ... And there are some of them [ACNPs] who never get that; they can't see how urine output is correlated to blood pressure, is correlated to this or that, and so they're not thinking about the whole big picture.

The ability to make a difference for the patient, the family, and also for the team in the clinical practice situation, is an important element of "feeling" like an ACNP and emerges from *being competent*. There is a strong sense of satisfaction in what they are able to accomplish as a result of how they manage the clinical component of their practice as ACNPs. Finesse in handling a situation that would have been overwhelming in the past, increased technical skills, and the ability to direct others knowing that they will trust their clinical judgment, are described as triumphs. With this triumphant feeling comes the first sense of *being an ACNP*.

Being competent is demonstrated in the ACNPs' ability to make decisions under pressure. Both the ACNP and members within their community of practice no longer doubt that both their thinking process and skill performance can be repeated successfully under most circumstances. Perhaps *being competent* is most dramatically revealed in the ACNPs' replacement of the words "I don't know what to do" with "I know what needs to be done," an outward reflection of an internal belief about one's abilities to successfully perform independently.

> I mean as you're training you're just learning and it's kind of like - I better call [physician] on that because I'm not really sure what's going on or I'm not sure what to do. But, for example, a child with hydrocephalus who's vomiting and very acutely ill with a bulging fontanel, I know what's going on and I know what treatment needs to be done. So you call down to CT and you say - can you squeeze in [patient] because he's having another episode - and you know, you don't wait for the neurosurgeon to call back. You just know what's going on and then you just make the appropriate treatment plan.

Being competent as an ACNP not only means completing the newly acquired clinical tasks in an efficacious and timely manner, but also being able to anticipate future problems for both routine and rapidly changing, non-routine events from both a medical and nursing clinical management perspective. As a consequence, attempts are made to control for them by mapping out a plan of care, helping the team to prepare the environment, having the appropriate equipment and resources at hand, all the while fully realizing that the patient's actual presentation or responses to the interventions may very well alter these plans. The ability to do this, which Benner, Tanner, and Chesla (1996) previously illuminated as a major temporal shift in perspective in the novice to expert transition of staff nurses, is often the point at which an ACNP is able to say that she "feels" like a "real ACNP."

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[20] Cited in Perez-Reverte, A. (2001). The nautical chart. (M. S. Peden, Trans.). New York: Harcourt

Being able to anticipate the demands and possible eventualities places the ACNP in a new relationship to the situation. There is a sense of feeling in control that was not heretofore experienced in this role. Paradoxically, *being competent* also means that there is an acceptance that there is no such thing as ultimate control over a situation; yet there is an ability to live with this clinical uncertainty in a taken-for-granted way. *Being competent* means being willing to take the risk of and carry the responsibility for clinical management of the situation, even though there is a recognition and acknowledgement that patient outcomes cannot be guaranteed and not all outcomes are positive.

ACNPs who perceive themselves as *being competent* are able to engage in multiple tasks simultaneously and can direct others without hesitation. They become more selective in what needs to be done, what can be delayed or ignored, and what short cuts can be taken safely. Experiences allow them to see that not all clinical issues being brought to their attention need to be addressed right at that moment and delaying some decisions does not lead to negative consequences for the patient, family, or staff. Putting off today what can be done tomorrow, such as reviewing routine results of patients' diagnostic tests, occurs when there are other priorities that need more immediate attention. As importantly, this type of situation is experienced without a pervasive sense of foreboding. The ability to prioritize what can wait demonstrates another temporal shift (i.e., what is in the present can be placed into the future), a shift that is integrally connected with conscious, calculated risk taking.

Being competent is also characterized by the ACNPs' demonstrated ability to refocus quickly despite numerous interruptions, discovering that they are able to deal with multiple issues at one time. They find they can hold in their mind the information about multiple patients with their complex issues and needs. The numbers of patients they can care for efficiently and effectively increases so that they are left to manage patient care by themselves. They are no longer overwhelmed by the number of issues they have to address throughout the day and speak to the various types of activities with which they are involved with such a quick and carefree manner that one senses an embodiment of these activities. The following account of one ACNP's description of a typical day in an orthopedic clinical practice is offered here to facilitate an appreciation of *being competent* as an ACNP and when it is they are able to identify with *being ACNPs*.

> [When I am in pre-admit clinic] I tend to come in a little bit earlier because I'm going to be off the floor for a good part of the day. So I come in and check lab work on patients if I didn't have a chance to do it the day before. I'll look at what patients are being discharged that might need some follow up by me or make sure they've got prescriptions. Some patients might be going on Coumadin, so I need to look up what their INR was, call their GP, fax information to them, make sure the patient has a good understanding of what's going to happen for discharge. So that's done quickly. The doctors may do rounds first thing in the morning, so I would do rounds with them and we determine who's being discharged, what tests or things need to be done. I try to get all those things cleared up before I then go down to pre-admission clinic. So then in the pre-admission clinic I usually see six patients a day. So down there I do the medical or health history, do a physical examination, write the pre-operative orders. I tell them about what they're going to expect when they come in for surgery, tell them about their surgery, the protocols after, like antibiotics to prevent infection or what we're going to give them for DVT prophylaxis to prevent clots, what the plan would be for discharge, if they're going to go to a rehab hospital or home. If they need [home care support service], that's explored. I also do the bone donation screening for patients. So if they're having a hip replacement, they've got a femoral head that could be good for bone donation, I go through the screening of that with them. I also may enter a patient into research studies. ....When I'm down in pre-admit I would have seen six patients a couple of days before and quite often the nurses down there are bringing me their lab results or chest x-ray results and then I look at them to decide whether further things need to be done. Occasionally they need a CT scan to evaluate a nodule that might be on their chest x-ray or they might have a urinary tract infection. Some of them don't have family doctors so I would have to follow up and come up with an antibiotic and fax that to a pharmacy or call it to a pharmacy to have them treat it before their surgery. Other issues around the patients' care can also come up, in discussion with either anesthesia or medicine who are also down there. If they're high risk for medical problems or anesthetic problems then I'll discuss with them down there that care and what needs to be done. Occasionally there's an issue that comes up that I have to consult with the orthopedic surgeon at some point and I will jot those down and then deal with those at a later time. While I'm down there I'm constantly being paged from the floor for issues that patients have, so whether they've got a low hemoglobin or maybe have some sort of a crisis that sometimes I have to come up to the floor and assess them and order ECGs, troponin levels, things like that too, and then based on those results I might have medicine or cardiology or somebody see them. Occasionally I might be assessing a patient for a knee replacement, but when I do my assessment I find that their hip is far worst than their knee, and so I change what orders are written. I talk to them that based on the x-rays that are done today we might be changing your surgery to a hip instead of a knee. So I'll do things like that too and then review it with the consultant at a later date. I might x-ray other things like shoulders or backs, depending on what I find down in the pre-admission clinic. Occasionally I cancel a patient's surgery. So if they've got an open sore on the leg we're going to do the hip or knee replacement on, infection is a big concern. So I will do that too.

Despite feeling somewhat intimidated by the presence of onlookers, particularly family members, the ACNP is able to step away from his/her own needs and recognize and acknowledge the others' need to be in attendance. They are aware that others, inclusive of patient and family, must have trust and confidence in their abilities as well as those of the team. Having confidence in their competence, ACNPs are willing to acknowledge and accept the trust that others have placed in their abilities. As a result of this acknowledgement and the acceptance of the responsibility it carries, many work hard to create a team dynamic that is calm and synergistic.

Being competent arises out of a certain degree of efficiency in the performance of skills, decision-making, charting, and communicating and results in "medical" aspects of practice being gradually taken-for-granted. As a result, ACNPs begin to draw from their nursing background and actively integrate who they are as nurses into their clinical practice (although it may take much more time and experience to feel satisfied with how they are able to do that or in such a way that it too becomes taken-for-granted). Now that they know that they can "think like a physician," they actively pursue the integration of this form of thinking with "thinking like a nurse." In fact they now proudly display this. They may even challenge the physician, recognizing that what they do as a nurse makes a difference in a way that could not be realized within the medical model of care.

> Well you know a few of them have said to me, "Oh you're thinking like a nurse again", as if it's a bad thing [laughs]. And I don't take it as a bad thing. They are thinking more, what's this person's immediate problem? What's their immediate health problem? They're not thinking that they can't be late for this appointment because they've got their son to pick up at 3:15 at school and that kind of thing [laughs]. Like it's more health problem centered; it's more - what's your initial problem, I'm going to solve it, and then off you go on your way. And they don't really take into account the rest of the patients' lives and what's going on with them. ... Whereas I like to know more about the people and more of the social aspects than actual medical base. But I think it's important too because I think it all plays in. I mean often times when we have patients, the very sickest ones that have to have continuous intravenous infusion of Flolan, which is a pulmonary vasodilator, all they can do is walk around with this little cassette with this infusing constantly. And quite often a couple of them will come in with headaches and "something's wrong with my Flolan or the pump." Well no they've had a fight with their son. So it's the other things in their lives that are going on that if you just sit there and talk to them, things are okay, and you don't need to change anything medically because there's really nothing medically wrong. So I think it's just as valid as dealing with their medical condition.

Nursing assessments are integrated with the medical history and physical, creating a more holistic health history. Not only do they make the decision about what medication choices are available as part of the treatment plan, but they are able to free time to explore those options with the patient/family as to the best fit for them. After writing a prescription, they find themselves able to integrate patient teaching into their clinical practice. They have time to focus on the anticipation of future needs of the patient and family and can include long-term planning into their care management. Rather than being focused only on clinical management of the disease process and/or dysfunctional organ(s), ACNPs integrate potential with actual patient care needs, addressing multiple physical needs, even those associated with normal healthy living. For example, neonatal ACNPs anticipate the need for immunizations in the infant age group, while paediatric oncology ACNPs foresee and address potential sexuality and child bearing problems with adolescent girls with cancer. Once a myocardial infarction has been ruled out in the chest pain assessment clinic, cardiology ACNPs use the opportunity to explore lifestyle choices with the client and engage in health promotion teaching around smoking, exercise and nutrition. Indeed, this ability to finally re-embed their clinical management practice within a holistic framework as part of the moral agency of the ACNP will be explored in much greater depth in the threads of *being connected* and *being committed*.

Experiencing competence results in ACNPs articulating the assuredness or confidence they have in their abilities (competence). They are able to state their own strengths and provide examples of it. They are also able to provide examples of other's affirmation of it. As one participant who works in pediatric oncology noted, doing bone marrow procedures has fallen to her not only because she likes to do them, but also because she is "fast and good." Another acknowledged:

> My expertise in orders on the ward has become very, very high. So any orders and change of IV fluids and change of pain medications, in assessment skills, have become very, very good.

Therefore, ACNP competence, as demonstrated by these examples, is the habitation of leadership skills in the clinical management of the patient. Leadership skills are perceived as decisive problem solving regarding the medical care of the patient, in a calm manner, with a global perspective to the patient's physiological needs and an overall awareness to the situation, combined with good communication of that care to the patient, family, and team members. For ACNPs to be acknowledged by self and others as competent they must demonstrate critical thinking and prioritization abilities, skilled technical abilities, appropriate resource utilization, organization of thought and actions, all of which are integrated with stress management techniques. As one ACNP explained, *being competent* is:

> Triaging, trying to determine when patients tell us they have chest pain, is it musculo-skeletal or is it cardiac, or is it something else? And we kind of make that determination as NPs. You know, 'my shoulder's sore'. Well if it doesn't go away, let me know kind of thing. We're presented with those things all the time by virtue of seeing the patient twice a week I think. ...So it's that determining what's a problem and what's not. And then how urgent is the problem? Can it wait? Can it not wait? Can it wait a week? You know - GI bleeding - how bad is the bleed? You know you're watching the hemoglobin every dialysis; you've

> adjusted the heparin; you've adjusted some of the meds; and it's like - that GI clinic is in three weeks. Okay, well can they wait or not? That type of thing. Moving tests up. Can the CT wait two months? Does it need to be done now? Sometimes you have to get the physician involved. You try and move it up and you can't so then the physician needs to make a phone call. So through the decision-making we certainly have some knowledge to make the decision. Of course we do a history and a physical exam and that type of thing to be able to help make the decision, talk to the family, the patient, the nurse, what's the nurse's perception of it.

Being Confident

> A lot of it is just self confidence, knowing that I'm becoming more confident in the role. That's what I find to be most satisfying.

The experience of *being confident* in one's clinical abilities as an ACNP is threaded throughout the lived experience of *being an ACNP*. Confidence comes from the Latin word *confidere*, whose root word *fidere* means to trust, to believe, and to be true to (Barnhart, 1988). As ACNPs acquire more knowledge and skill as applied to their clinical situations, they gradually start to believe that they can be en-trusted, by both themselves and others, to do the right thing for their patients and families.

> So I've had to learn to say this is why I'm writing this and I know that this is right and move on... I'm satisfied that I'm doing it right, it's correct, and nothing bad's going to happen...The first time I felt like a NP was probably when I felt more confident and I felt I was doing a good job and was on the right track and things were coming together.

> I found as a NP it took me two years to get confidence and comfort to say yeah I made the right decision. And there's still times now that I go, 'Well, I hope I make the right decision.'

A state of certainty about the outcomes of their performance is gradually acquired, which slowly evolves into a state of well-being about the medical aspects of care they now have permission to do. But how does *being confident* clinically manifest itself in the ACNPs' experience? How is *being confident* clinically connected to *being comfortable*? Does the ACNP experience *being confident* through a feeling, or is it experienced as knowing about one's capabilities? Must there be a certain amount of practice to be clinically confident as an ACNP?

Gradually, feelings of self-doubt are replaced with self-assuredness. ACNPs know and acknowledge that they are able to do what is required of them. They find themselves able to give what they call "timely responses" to patients, families, and nurses' concerns without the need to "second guess" themselves. They do not constantly check their reference books or double and triple check their orders; nor do they need or want to verify every decision with a physician.

> So now three years later I'd say for most diagnoses I know what it is, I communicate it with the parents and talk about the plan of care even before the physician comes into the room.

> So if I'm confident enough that I know what the plan of care is I will go ahead and speak to the family just because we do have protocols and based on what we see there's a pretty standard outcome to what we see and what the diagnosis is. …So I would say confidence and knowledge has definitely increased, so that I would go ahead with a diagnosis, with a plan of care, and not have to run back to the surgeon and double check.

Being confident is evident in their ability to discriminate between ordinary and unusual decision-making situations in their specific clinical practices without a pervasive sense of doubt or hesitation. They differentiate between decisions that are easy due to their routine nature, despite complexity, and those that are difficult due to complexity that is combined with newness or rarity.

> Well I guess when it comes to some of the routine things that we see – and when I say routine, I mean it's an ICU setting – so you understand what I mean by that, right? [Interviewer nods yes] Okay. So, if this happens you do this. You know there are some things that are quite, let's face it, if you don't have an airway, you get an airway; you know those are easy. But when you start getting into some of the more complex things - you know now with IVF [*in vitro fertilization*] we're seeing way more multiple deliveries and complex multiple deliveries, not just twins, twins are like routine, now it's triplets and quads.

In fact, *being confident* means ACNPs describe parts of their practice in terms of the "simple, mundane" things with which they are engaged on a daily basis. As one ACNP working in cardiology described, "by the time you've been doing it for four years, 90% of it is routine. So instead of it being 10% routine and 90% new, it's now 90% routine and 10% new." This sense of routine comes out of an ability to recognize when one experience is similar to another. This pattern recognition makes ACNPs feel more self-assured about their decision making. "And then it becomes routine; even reasonably complex patients become routine because you're used to dealing with them." When ACNPs experience *being confident*, no matter where they work, they describe that with enough experience they are able to "accurately pick out" the "common" or "normal" sets of problems with which their patient population presents.

> Like uremic syndrome is a biochemical entity and I can diagnose hyperparathyroidism and I can diagnose hypercalemia and I can diagnose pulmonary edema and I can diagnose coronary artery disease and myocardial infarction. ….There's a lot of cardiovascular problems, there's a lot of endocrine problems, and I'm comfortable enough making those diagnoses and intervening, and beyond that, I think they probably need a doctor.

> Most things are fairly common okay. The babies that come in, they're premature or they have lung disease or they have cardiac disease or common surgical problems in their abdomen. There's this group of things that fit with neonates and then there's some weird things. And some of those weird things I don't see a whole lot and so I may be able to describe them and know that it's not normal, but those types of things, you're working as a team to figure out what's going on.

> So I feel very much more confident I guess in myself in this role. I think because it's such a narrow disease-base too, that I mean, you're pretty confident when you do physical

> assessments on people and what their treatment should be and what their diagnostics should be. General practitioners don't want to deal with it [disease population] because they see maybe one every four to five years; we see them every day.
>
> Well, it [making a diagnosis] comes as second nature really. [laughs] I don't know. It's very rare that I don't know what the diagnosis is. And if I don't, then I know I always have somebody to ask. So 95% of the time I'd say I know what the diagnosis is. ...If I don't, for example, if it's a tricky spine question or I'm not sure what's going on, then I'll collaborate.

ACNPs learn to discern what they know versus what they do not through this recognition of a pattern to their decision-making in the clinical management of the patient. Gradually, the sweeping feeling of not knowing anything at all, noted earlier as a common feeling experienced in *Being Adrift*, fades away in the distance. This knowing diminishes their anxiety concerning the responsibility they carry and their fear of causing harm to their patients. As a result, the number of times that the ACNP feels disabled by the responsibility that they carry becomes less frequent and intense over time.

> [Being scared] it's not as pervasive; like I can order Lasix without being scared now for sure, every day, like candy, pass it around. And I think I've developed a certain level of confidence in what I know, what I can handle, and also in what I can't handle, and knowing also, having worked with the medical team for awhile now, being able to say, "Guys I can't handle this. You know I'm going to take care of this patient but I need quote "back up" now because I don't know what's going on. So I think this being less scared is being able to identify what I can handle and what I cannot handle. And at the beginning it seems that it's not that easy to know what you can and what you can't handle, and what becomes more routine with time. Just like being a new nurse, doing that first IV, doing that first something, until you have a few under your belt, then it's okay.

This pattern recognition associated with decision-making helps ACNPs feel secure in their belief that they know, even in unfamiliar situations, what is the "right" thing to do. Certainly the pattern recognition process has been explored in great depth from a clinical reasoning or clinical decision-making perspective (Dowding & Thompson, 2002; Dowie & Elstein, 1988; Eddy & Clayton, 1988; Fischhoff & Beyth-Maron, 1988), but what is of particular import here is its relationship to the experience of *being confident*. For example, the following account of an ACNP's description of the first time she felt like a NP. She described how she had been able to quickly and accurately diagnose the patient problem and how it needed to be solved. She engaged in multiple tasks simultaneously. Finally, she was able to direct others without hesitation and others also followed without hesitation. These behaviors are all manifestations *of being competent* clinically. Her actions resulted in a timely "cure" of the patient's particular problem at that moment in time, which consequently made her feel good. She acknowledged how she suddenly came to the realization that she could successfully initiate a timely intervention in the immediate crisis situation. At the same time she could accept that it was okay not to know everything that had to be done or even if the diagnosis was ultimately accurate. In experiencing *being confident*, she was finally able to identify with being an ACNP. To call in someone who knew what to do no longer affected her self-esteem and self-confidence as an ACNP. She accepted the limitations of her knowledge and skill while still feeling for the first time that she was a NP, a NP who could make a difference for her patient. In other words, she no longer felt that she had failed the patient or that she was intellectually unable to make and act upon the appropriate clinical decisions. This was contrasted to a time in which her hesitancy, indecisiveness, and lack of confidence in the moment necessitated that she call the physician before she could act on her thoughts. As a consequence, she had felt inefficient, ineffective, and disheartened that she had been unable to make a difference. Referring to herself as a novice in this latter situation, she acknowledged that she was unable to perceive herself as an ACNP despite titling, education, or others' perceptions of her *being competent*.

> And it was a woman who once again was having her first hemodialysis on an evening shift and I was working this shift. And she had just had a perm-a-cath put in - and they were always x-rayed - and we put her on dialysis, and she started going into acute pulmonary distress. And I listened to her lungs and I could hear nothing on the right side. And she had a diagnosis of Wegner's which is an autoimmune disease that causes problems with both of the lungs and the upper respiratory tract, but I didn't think that was an adequate explanation. And so then I quickly thought about what are we doing to her on dialysis, and this is a new catheter, and I hear nothing here. And I wouldn't know very much about a shifting trachea but it looked like it [used her hands to demonstrate on her own neck]. So I wasn't able to intervene here, other than to stop the dialysis. I stopped the dialysis and - I didn't stop the dialysis, I asked the staff nurse to stop the dialysis - and I ordered, actually simultaneously ordered, a STAT portable chest x-ray and called the medical resident on call. And she had a hemothorax. ... I guess part of it is handling critical situations in an effective way, and know [pause] and it stands ...in contrast to that poor unconscious lady my first evening shift in the unit where the very first thing I did was call [the physician], you know, whereas [in this example] I had already made a diagnosis, something of a diagnosis, when I called the resident, and I had stopped the dialysis. So the right things had happened.

Being confident means ACNPs no longer feel disorganized. Consequently, they do not automatically blame themselves for being unable to get everything done in a timely manner. Although time constraints continue to frustrate them no matter what their level of expertise, they are able to reflect on what is in their control to manage versus outside their influence in the situation. They identify when the workload is too heavy and will ask others, such as another NP or resident, to help them with their work. They admit to themselves and others what they have been unable to attend to without feeling shame or personal inadequacy. They do not feel a sense of having failed or that they are not "good enough." In other words, they put their workload into a larger perspective, which is facilitated by their ability to prioritize what is most important and what can wait, the latter an aspect of *being competent*.

> Because there's days where you know what, you may have seven kids to see in the morning before rounds; you might only see two, because when you got to number two, things were not good. And so then you've got to deal with the fact that you've got five more kids you haven't seen and you're going to be doing rounds and, and there's no way that you can get it done. I've learned now to say, like if the fellow is finished his patients, I'll say, "Do you mind checking or mind going and seeing these?" I don't mind asking for help or just admit, saying when we get in rounds, "I haven't had a chance to see this patient".

ACNPs discover that they "know and trust their own instincts" so that they can "move" or "dive" into the fray easily and quickly. They describe feeling and believing that they can "handle any curve balls" thrown at them in a way that does not immobilize their thoughts or actions, despite feeling scared. Feelings of uncertainty are less frequent, although do not totally dissipate. In the following passage, it is evident that *being confident* means that ACNPs no longer need to mentally and psychologically prepare themselves for the problems they might encounter. They feel enough self-assurance to "wing it" when problems present themselves unexpectedly, be they patient-related difficulties or "curve balls" associated with working with an inexperienced team. This marriage of *being confident* with *being competent* leads to a willingness and ability to direct others who are novice or unsure in the situation. This demonstrates the ACNPs' ability to see outside themselves in the situation to the needs of others in order to help the team function efficiently and effectively. The merging of confidence and competence allows the Other to move to the center of their consciousness and as a result they can now truly "be with" the Other in a way they could not before. At this point, the emergence of the ethical with the clinical in a way that is more congruent with the wished for "perfect fit" comes into view. Other in the clinical situation is now extended to the patient's and family's well-being as noted earlier, or the staff's learning needs in the situation, while simultaneously attending to the patient's physical clinical management needs.

> INT: Give me an example of a curve ball.
>
> ACNP: As I said, something like going to a delivery, where it's just a few fetal decels, probably variable decels, nothing. You know, standing and talking with the nurse who's come with you, everything's been good, and all of a sudden they bring you a flat baby. Oh, you're just expecting you might have to just do a little drying and warming, maybe a little oxygen, and you're in a full blow resuscitation with CPR and lines, and you're going hmm, this is a little more than I planned for. Where again after the fact - and it was a nurse who had never been down there before and she was so concerned. I remember her saying to me, "Do you want me to get somebody else to help you?" And I said, "No, no you're doing an absolutely wonderful job. If you do this I'll do this, someone go and get the cart, and someone go and call upstairs and ask them to send a Fellow down to help me," and you know it just went really smooth. And afterwards she was like, "I'm so sorry. I probably

> wasn't good enough." And I said, "You were excellent." I said, "You did a really, really good job."

With increasing self-assurance in their own level of knowledge and skill, ACNPs' clinically-based knowledge takes on a broader range of pathophysiological issues. Yet, as a result of now knowing what it is they know and what it is they don't know, they also become confident negotiating the boundaries of their scope of practice. Consequently, they can articulate and defend their scope of practice for their specialty and context and emphatically state what they do not want to know, nor should not know. As one participant working in nephrology laughingly said, "I don't do neuro" and "I've never put in a chest tube and I never will. I'm pretty clear about that." In other words, they confidently and comfortably place boundaries around the knowledge and skills that they need to bring safe and timely care to the patients in their practice setting. *Being confident* means there is a more realistic understanding of limits to their scope of practice and their responsibility within those limits. As on ACNP explains:

> You know, I think some people think that they're responsible for the entire world and I don't ever try to assume that. Because I know there's one person kind of doing that now and she'll always say, "But I don't know everything." I just have to keep saying, "You don't have to know everything. I think you know what you need to know and then you now have to be confident, be willing to admit that you don't or seek help and guidance when you do, but you don't have to know everything. ...You do have to seek guidance and things like that; and you just have to know your own things. You don't have to know everything." And so I know that I don't know everything and I know my limitations and then I'm willing to go out and do that.

Being confident clinically is influenced by others, particularly the physicians with whom they work, and when applicable, other nurse practitioners. For most, it is a continuous process of renegotiation in order to ensure that the boundaries created continue to be honored. As a point of illustration, an ACNP who carried the responsibility for performing all the tracheostomy changes within her institution, described the process of negotiation in which she was about to engage with a physician new to her clinical team. This physician, having observed her practice, suggested that she, not the ENT medical resident, should be responsible for performing the patients' tracheostomy changes sooner than was her current practice. In this case, a change in the timing of the procedure amounted to a change in the scope of her practice. She acknowledged her "reticence" about the request, recognizing it was born out of the prior deaths of two children during tracheostomy changes before the stomas had been well established. These deaths had occurred even when they had been performed by ENT specialists. Yet despite her reservation, she was open to examining the various levels of evidence regarding patient outcomes, the additional training required to manage premature closure of the airway, and the system changes that would need to be instituted to safeguard the patient. *Being confident* then is demonstrated by an ability to see one's own strengths and to link those strengths to the salient issues in the situation and to ways of responding to the problems identified. These abilities are then brought to the fore in the negotiation process.

There is, however, a paradox inherently associated with *being confident* in one's competence and in the management and appraisal of one's scope of practice. As ACNPs gain mastery of the clinical management component, they also begin to face new and uncharted territories as a clinical expert in their role. Tensions arise when they begin to surpass the expertise of their physician colleagues, while at the same time they still need their assistance as a result of finding themselves outside their scope of practice. Struggling to do what is right for the patient and for self in the situation is clearly evident in the following account of an ACNP who encountered difficulties during the performance of a lumbar puncture.

> He was obese, very, very obese. I was blindly doing the procedure and I thought this is out of my scope. I don't know the anatomy well enough. All the physicians that were in the room – there were two surgeons and an anesthesiologist - and I had been the one that had done this child ever since he was diagnosed, but he continued to get more and more obese. I did him with an eight inch bone marrow needle the first time. This time I couldn't reach him with an eight inch bone marrow needle. I was blind. I was blind. And I called the oncologist and he was busy and he also said, "[participant's name], you're the most skilled of the group. You've done him all the way through." And as I was doing it, I thought, "Yeah, I am. I agree with him. I am. But I know the least about the anatomy of them all." .... [And] I did it, [pause] but I thought - I am out of my league. ...Like I was out of my league, like way out. I didn't have the skill-base to know what I was digging at. But then I didn't think probably any of them were either. Only a surgeon would have been able to know what he was doing and probably I should have deferred to a surgeon, not to even another oncologist really, not to an oncologist, but to a surgeon. ... And I thought, you know, what do you do? I mean, we were just not trained. And then do we have the right to, can we say, "No I will not do this procedure. I refuse?" Of course you can, but when someone says you're the most skilled of the lot, can I still say no? Of course I could have still said no. What I actually asked then was if they would mind me going to a different site, which they said they agreed that I could switch sites, just to do anterior, which they don't like me doing, but again they deferred to me as I was the most skilled, which is true. I've been doing the most in the last seven years. But it was an interesting position to be in. ... And just as he [the oncologist] was walking in the door, I got it. I got the specimen and it was good and everything was great. But the fact that he came down, that sort of refreshed my faith in him.

As this passage illuminates, *being confident* means that ACNPs acknowledge that they have a strong clinical grasp of the situation. They recognize both the familiar and individual patterns of responses as well as a clear sense of when they are outside their scope of practice based on the unfamiliarity of the clinical territory in which they find themselves. As this account illustrates, there is marked congruence between the confidence that is expressed by self and others in the ACNPs' competence. In fact, both are even able to comfortably acknowledge when the expertise of the ACNP exceeds that of the physician in the particular clinical situation. Yet awareness of uncertainty arises because of knowing when they are outside familiar territory without the requisite knowledge required to legally engage in the activity. But the tension that is experienced is different now than that which was experienced in *Being Adrift*, where not knowing what they don't know is the standard phrase. *Being confident*, however, results in an appreciation that they may have capabilities that others do not have, even when the demands of the patient situation may exceed their own capabilities, and even when their capabilities may not be legitimately recognized in a court of law. As this ACNP acknowledged, "my insurance crossed my mind actually and would they back me up?" Indeed, *being confident* is characterized by recognizing the current response capacities (competence) of other health care team members present as compared to one's own (including one's limitations). This recognition is then linked to the sense of timing that is required of the action for the sake of the patient and is quickly cross referenced to other available options in the particular situation. All this information then culminates in a clinical judgment that is based clearly on a risk-benefit analysis.

This ACNP's narrative shows us the high element of internal struggle that was ongoing during the enactment of the procedure and demonstrates the burden of working in situations that have both boundaries as well as possibilities for pushing those limits. There is no sense that the ACNP needed to be the hero in this situation. On the contrary, she reached out for help but quickly realized that in this circumstance there was no one available with greater skill than herself. She struggled with identifying who and what was the best way to carry out the procedure. This experience demonstrates that *being confident* as an ACNP constitutes prudence in recognizing the strengths and weaknesses of self and others, articulating one's limitations, knowing that one's practice cannot be done in isolation, and mobilizing a more effective plan for the future.

Being confident does not eliminate moments of doubt. But while most nurses are able to turn to the cumulative and collective wisdom of their group for advice, the lack of a well-established homogenous community of practice is strongly evident in this ACNP's narrative. This ACNP described being so "shook up" that she approached a student in the NP program to talk about the event. However, the student herself was so overwhelmed with her own confusions that she actually requested the ACNP not discuss it with her. She contemplated discussing the experience with the nursing faculty where she had trained as well as her professional association. Unfortunately, her previous experiences with these potential support systems had lead her to believe that they were as much in the dark as she was when it came to making decisions about the ACNPs' scope of practice as it was actually lived in the practice setting. She also stated that at the time there were no other ACNPs with her particular subspecialty in Canada that she could contact. As she said: "What do you do? I didn't know who I was going to call."

In short, this ACNP's struggle remained unresolved. In the retelling, the ACNP realized that requesting a surgeon who had the necessary anatomical knowledge embedded with experiential expertise may have been a better solution and an option she had not considered at the time. Two questions that are brought into consciousness by *being confident* and *competent* are held in the balance for the ACNPs who pioneer this new role: (1) Who carries the responsibility for the risk taking associated with the decisions made at this level? (2) Who is best to take the risk in each particular situation?

As identified in the above illustration, one of the manifestations of self-assurance is the willingness to take risks. When ACNPs finally experience *being confident*, they begin to make the decision when "not to act", or in other words, when not to over-treat. Ultimately, being an ACNP is "learning to do what is in the best interest of the patient, not what is safest for the nurse practitioner." Coupled with *being competent*, the ACNP gradually begins to find the fine line of being cautious while not overly cautious, along with seeing the patient within a health care system that also needs to be tended. As one ACNP noted, confidence involves "not ordering fifteen tests when three would do because you have to consider the cost to health care." Therefore, *being confident* also means that ACNPs do not always play it safe by doing everything all the time.

> And I do think that people can take care of patients just by doing everything. And I tell people the hardest thing is **not** to do a septic work on every baby. That's very easy. Every time they have a whimper or whatever I can do the whole, send all the cultures off and start them on antibiotics. A much harder thing is to try and take all the information and not do one, because you can always play it safe and just order one up every time. But to try and say, "No, I don't really think it's an infection, this is something else," that becomes harder to not do everything. ... There isn't a lot of good reason to do this except to make you feel good, or to think I'm doing something. That isn't necessarily the answer all the time. ... But then they never progress anywhere. If you stop feedings and start antibiotics all the time they just never make any progress. ... You have to get to these points and you have to kind of make that jump sometimes. "No it isn't that and we're just going to progress and stay on with this course." And so I mean that's I guess another part of the whole challenge to move the patient forward to get out and go home, because the day-to-day operations if you don't see that forward progress, well the patient could stay here forever and have this test and that test done, but you're aiming for this overall progression and when you see them every day and you see them regularly that's what you want to see, that they're making progress.

Being confident is also characterized by ACNPs intentionally holding off or delaying informing and/or discussing clinical management decisions with the staff physicians. Not only does the physician trust their clinical judgments, the ACNPs also trust their own decision-making abilities. The need or desire to connect with the physician is limited to situations that are new and unfamiliar or easily recognized as being out of scope of practice. In fact, this confidence and comfort with their decision-making often flows over into dealing with non-specialty issues. Believing in and trusting their own clinical knowledge, skills and abilities, they experience, as well as demonstrate, control in the situation. Even if it is outside their scope of practice, they still believe they can manage the event until the physician is able to come to assist them. In fact, they differentiate between keeping the staff physician informed because the latter is ultimately responsible, as opposed to consulting a medical expert who can better deal with the issue and/or can provide affirmation.

The following passage illustrates these characteristics of *being confident* and helps convey the reality that *being confident* and *competent* are co-experienced and are inter-related parts, whose embodied whole is greater than the sum of its parts. In this situation the neonatal NP recalled how she had been summoned to the delivery room to assist the team with the resuscitation and stabilization of an "apparently normal" infant born of an elective cesarean section. On arrival she discovered that the baby's "breathing was entirely abnormal" and the team were experiencing difficulty with the intubation. She immediately suspected that the baby had a tracheoesophageal (TE) fistula and "given he was having so much problem breathing," she knew she had to try to intubate him. It becomes evident that the ACNP has a clear understanding of the normal patterns of response to an intervention and as a result can readily acknowledge that she is no longer in familiar territory. Her confidence in her competence is demonstrated in her ability to use her knowledge and critical thinking skills in such a way that she can calmly mentally work through potential diagnoses and possible actions. At the same time, she is able to observe the infant's responses to the actions she employs in a trial and error format in this time-pressured situation. She continues to respond quickly and fluidly while simultaneously managing multiple tasks. Even though she may desire to be able to do more for the patient and family, her skilled performance is linked with her ability to honestly judge her own capabilities without berating or demanding more of herself. *Being confident* allows the ACNP to call for assistance in such a way that she now works with the physician in a collaborative partnership rather than a hierarchal relationship. In this way, she retains a sense of responsibility for the patient's well-being rather than abdicating it to the physician.

> So when I went to intubate him it just made it worse. If you can imagine, you're suppose to be helping this baby out and it just made it worse and it's just all this stuff, you know, is going through your head - well I know I'm going in the right spot, it's passed through his cords, but as soon as I do this it actually makes it worse not better. Like I can give this baby CPAP and give him hand ventilation and it works much better than it does when I intubate him, so what is the problem? And so going through that and saying okay, if this baby has a TE fistula then it can be that sometimes once you pass the endotracheal tube that you can go into the fistula and so that you have problems ventilating them or that you're hiding the fistula and all of your pressure actually goes to the stomach instead of where you want it to; it just depends on where it is, sometimes, you know, it just depends. It was really queer because when you passed the tube it wouldn't go any farther. This never happens, like once you pass it, it should be just pretty well clear. And I was thinking, there's something happening here that is just totally strange … and you know I'm making him worse not better, so I'll just continue with what was making him better, which is the positive pressure ventilation and maybe just the CPAP and let him do the work himself. He needs some help but I can't do it. I'll get lines in him really quickly; so I got the lines in so we could monitor his blood gas and how he was doing, and I also phoned the neonatologist and said there's something really strange and you have to come in. And he wasn't really happy. He said, "Well if you don't know, how am I supposed to know? But look I'm not coming." I think I said that you're probably right, we might need to call ENT for this; there's something wrong with this patient's airway; but I'm not sure that it's not just me." He says, "Oh [participant's] name." [laughs] But, he came in, he tried, and the exact same thing happened to him.

Through the creation of a caring space for the distraught family, this information is even honestly shared with the parents, another characteristic of *being confident*.

> And then the family was up in the unit while we were trying to intubate and you describe the procedure to them and then you have to admit failure in front of these people and I said, "You know, I've tried and it actually seems to make it worse so I'm just going to have to, I'll just leave it as is, give him the help that he needs in another fashion, and I'm calling in these people, and you know what it says to me is that there's a very serious problem with the airway and your baby; we know that your baby's going to need surgery but I don't know what else to say beyond that." So dealing with the parents at the same time all this was happening was very, very [challenging] - you know, all this decision making, what am I going do next? It's beyond me; do I keep on trying?

Despite the need to have physician assistance, *being confident* means that ACNPs do not take a back seat to the decision-making but continue to be part of the process and contributor to the plan of care. They do not want to step back but continue to direct the clinical management themselves. Control is shared rather than relinquished. Even when they are unsure of one aspect of the clinical management piece, they remain in the centre, directing what they can and complimenting the work of others. Expressing a sense of failure, as demonstrated in this situation, is not about having failed as an ACNP because of being inept. Instead, it is an expression of frustration at having been unable to do more, to make the kind of difference that one wanted to make.

Being confident clinically also creates the possibility for advocacy and taking an ethical stance. As noted earlier, *fidere* forms the foundation of the word confident. There is an inherent sense that to be confident also means that if the person is to be en-trusted "to do" the right thing by self or others, that person should perform in a way that is true to the intersubjective, social, cultural, and ethical concerns of the situation, rather than merely acting within a set of behavioral protocols or skills. It can be assumed then, that the more thoughtful and reflective ACNPs are about the particular situation in which they find themselves (calling upon all the ways of knowing that they have available to them), the more likely that they will be able to act confidently in situations marked by contingency and uncertainty. van Manen (2002b) regards this as a quality of tact. For example, there is a moral imperative demonstrated in the acts of acknowledging one's limitations in the situation and then insisting upon the involvement of their medical colleagues, even when those colleagues argue against the need to be involved due to their trust in the ACNPs' abilities. The ACNPs in both this illustration and the one regarding the lumbar puncture were not abdicating responsibility for the care of the child, nor were they fearful of carrying the responsibility. Rather, they were advocating for the best care possible by marshalling the appropriate responses from others. This comes from *being confident*, not insecure.

Being confident as an ACNP also means being situated in a collaborative relationship with the physician in a way that means being able to take a stand for the needs of the patients that may be different from that of one's medical partners. In reaching a place of respect for and belief in one's own competence, the limitations of the abilities of one's physician mentors in particular situations can be recognized. It means taking the risk to be an independent thinker despite the strong, dependent relationship that exists with one's medical colleagues. In this same illustration, the neonatal NP described how, after she had verified her impressions on the case once the physician made his initial attempt at intubation, she was able to protect this baby from further ineffectual intervention and possible harm by physically intercepting and definitively stating the need for surgical intervention. She expressed a combination of anger and disbelief that he would not recognize or acknowledge his own limitations in the circumstance.

> But unlike me he didn't stop and he kept going [loud and incredulous tone]. [Tone becomes soft whisper] And I take my hand on his wrist and say, "You know he's actually better when you're not doing this. I think it's time to quit and then just make the referral." .... I said we need to transfer him over to the [hospital]. And so he called the appropriate people and did whatever was necessary and it ended up the baby did have the most totally weird airway in

> the world; it was really non-operable. ... And then [the challenge] was the decision making for the neonatologist, you know, "you've got to quit now because you're just making him worse. This is exactly what I have done, I'm satisfied it wasn't just me, but now we have to call in somebody else."

The ability to trust themselves is promoted and strengthened when ACNPs are acknowledged for their clinical abilities; acknowledgement is translated to mean they can be trusted. When they know that others trust them, they are willing to take more risks. For example, *being confident* is characterized by the ACNPs' willingness to challenge the physicians and to question the plan of care. ACNPs no longer just accept the plan as offered up by the medical team.

> ...[V]ersus just doing what the doctor says you should do, or this is what the doctor does so this is what you do. More sort of saying well I'm not going to do that and this is the reason why ...and to question and not just to accept because that's how it's always been done kind of thing.

They change the staff physicians' orders or challenge their advice. They discuss patients' needs with other medical disciplines, debate treatment choices, and defend and support the decisions they have made. At the same time they recognize that there may be multiple ways of approaching the problem and that they can defer to others without jeopardizing the outcome, just as others can accept their choice of treatment plan. As one ACNP described it, "Somebody might question your management strategy, you know, the Monday morning quarterback kind of thing, but I'm just thinking you have to be there and everybody's doing it differently and that's okay."

Being confident is also revealed by the ACNPs' willingness to accept and embrace the responsibility of taking call as given them by their medical colleagues in affirmation of their burgeoning competence. They are eager to take on more responsibility for independent decision-making and are prepared to let the safety line be more distant, a sign of increased risk-taking. This is particularly evident in the constant interplay of the pronouns "I" and "we" noted in their speech. The use of the pronoun "I", particularly when associated with a quick tempo and authoritative or commanding tone of speech, demonstrates the ACNPs' willingness to carry the responsibility for the decisions they make and the confidence they feel in their thoughts and actions. "I" dominates the situations in which they make the decisions, while "we" is reserved for a sense of belonging and collaborative practice. In other words, "I" denotes the embodiment of accepting the responsibility that comes with decision-making in clinical practice, while "we" demonstrates the complementarity of both holding on to and sharing responsibility.

This is beautifully demonstrated in the following passage from an ACNP who works in a cardiac sciences service and who currently takes on-call responsibilities on weekends because of a lack of qualified physicians in their practice. This in and of itself could indicate that the physician colleagues in her practice trust her clinical judgment and decision-making abilities (i.e., her competence). But it is highly evident that the ACNP is confident with the decisions she makes when she is on-call as noted in her use of the pronoun "I" and her comfort with carrying the responsibility for her decisions even when the physician is at a distance. She knows the scope of her practice and when she needs to call for assistance. Despite the presence of a safety line, it is distant and she attempts to keep its use in abeyance. She is able to be solo without feeling like she is "in over her head." Although she demonstrates independence and autonomy, the use of the pronoun "we" also demonstrates a sense of belonging and commitment to the cardiology team and the patients/families the service serves. As well, its use denotes when she and the physician have made a decision together and responsibility is shared.

> Eventually when we're up to a full complement of cardiologists again that [weekend call] will diminish and I won't have to do that anymore. But currently as there is one cardiologist and myself and we have one point three million people to service, I currently do call at least two weekends a month. ... We have guest cardiologists who are okay, but they're not fully integrated into the system, and so it's just easier if somebody's on-call with them. So in that area I'm on first call, which means that if a call comes in from a community physician and they want to talk about a baby that they have or a patient that's known to us, then I will give them suggestions; I will tell them what I think; I'll arrange appointments for them to came and see us. If there are patients in hospital who require consultations on the weekends, I will complete those. I will only call in the cardiologist if we think that there's an echocardiogram that needs to be done because I don't do echos. And it's only if that patient can't wait over the weekend until regular working hours for the echocardiogram because the cardiologist just does second call. So even though I'm on-call he still has to be available to me. It's not as tight a call as what the first call is, but if we have patients in hospital over the weekend then it's my responsibility to manage them as well over the weekend without his help if I can absolutely manage it. ... He can say to me, "Well I want to go to [town] for the day. What do you think?" And I'll say, "Yeah I think you can be an hour away; that's not a big deal."

In due course, ACNPs learn to create a façade of "knowing" so that even when they do not have the full sense of understanding the intricacies of the situation, that is, the anatomy, physiology, or pathophysiological process, they are still able to exude a sense of confidence and ability to safely handle the situation. They appear to develop the embodiment of the medical aura, a phenomenon that has been described in the medical literature as a cloak of competence (Haas & Shaffer, 1987; Merton, Reader, & Kendall, 1957). Ironically, this cloak is not developed or utilized until ACNPs establish confidence in themselves, as evidenced by their ability to make decisions in a timely and autonomous manner. Yet when confronted with the awareness of their uncertainty, they don the cloak in order to communicate the impression of competence and confidence, of being in control of the situation. The consequence of controlling and manipulating other's impressions in order to be perceived as competent and trustworthy is that ACNPs increasingly identify with the role and become more confident. It would seem that there is a self-fulfilling prophecy quality to the authoritative performances that contributes to a changing perception of the self.

> Because you know what, people tell me I know everything. I know I don't know everything, but you know, I must present this aura of confidence that, yeah. I just don't tell everybody I don't know everything [laughs]. I'm not going to tell you right to your face. I need to have some confidence so that people can trust what I'm going to do and they'll listen to what I have to say, right?

Learning to project confidence, even when you have none, is part of the medical mystique. It is how you present yourself to the nurses, physicians, and patients/families that is as important as the content of that presentation.

> What I'm saying about other people is you've got to have confidence. If you present your plan of care as "well I think and maybe perhaps" [tone is slow, soft and hesitant], then the person listening to you is not going to or might not trust you as much as, "well I think this and so my plan is to do this" [bold and loud and fast tone]. Take out all the perhapses and the deciding thing and state your case and be prepared to defend it. Don't defend it unnecessarily because then they'll think - well you're not really sure. So you know it's a whole way that you, I don't know, present yourself to the world and things like that.

In an occupation that demands such a great measure of trust, ACNPs learn that they must convince legitimating audiences of their credibility. They learn the importance of playing an adequate role in order to exact the right kind of response from the health care staff and the patients/families. They quickly realize that the audience looks for cues and indications of personal competence. In response, they learn to organize a carefully managed presentation of self intended to create an aura of competence and confidence. ACNPs want to convince those they treat that they are indeed competent and trustworthy. They have learned that it is only when the patient and the health care providers (who carry out the treatment plan ordered) believe that the ACNP possesses these attributes that diagnostic intervention and prescribed treatment can affect the course of the illness in any positive way. In short, ACNPs learn impression-management in an attempt to communicate trustworthiness or self- confidence in their competence.

An aura of confidence is facilitated when ACNPs learn the community of practice's "routine" ways of treating a particular problem or the acceptable patterns of therapeutic interventions, along with "the thinking" or likes and dislikes of the various physicians with whom they work. Nevertheless, even after numerous years of experience, there are still times they experience uncertainty as to how a particular physician will think in a given situation. Yet, they are able to retain the illusion of confidence with the physician and team by being definitive with parts of the plan of care while being vague with others. They open up discussion in such a way that enables them to discover the thinking of the physician in the debate, thus retaining the ability to have input into and control over the final decision.

> And really when I make a plan now there's some things I'm very sure that they're going to accept, because you get use to a routine and how we now take care of the patients and things like that. And other things you're less sure of because you're not sure of how the physicians think. So you can kind of keep some of them nebulous even though in the morning you make your plan out, you order the things that you're sure of and keep the other things for the general discussion on rounds and then you could say yes or no to them.

This aura of confidence as portrayed by the ACNPs is not built on a false sense of competence. As noted above, *being confident* is built on competence associated with the acknowledgement of one's limitations. But, the ACNPs have discovered that an aura of confidence is necessary for those situations when they are living with the awareness of their uncertainty all the while needing to continue to effectively and efficiently mobilize others into a course of action. The aura of confidence continues to allow others to trust their abilities to do what needs to be done for the patient in a timely and safe manner.

> Well it always sounds like bragging but I'm very skilled at the clinical, extremely skilled - resuscitations, you know, doing procedures. And, even though sometimes I'm kind of a bit scared inside or you know things are happening, I don't project that. And the nurses have all told me that that's, they really like working with me because, well I guess they think I'm unflappable [laughs]. It's like, you know, you just project this calm experience and you've got to kind of deal with things when they come up.

Constituted in this aura of confidence is the acknowledgement that making a decision is almost as important as being able to make the *best* decision each and every time, the latter gradually appreciated to be an impossible task in many situations. *Being confident* means that ACNPs accept that the staff expects decisiveness and action, action that is enacted in a calm manner and inclusive of other's knowledge and skill.

> I've heard that they [the nursing staff] are not happy when you go to this person and you'll be lucky if you can get a decision, so they want you to make a decision. ...So they want you to be competent and be able to make a decision. In a crisis, they want somebody who knows what they're doing and doesn't fly apart. They also want to be respected. ...They do say that some people just kind of fall apart in a crisis and that's not very useful or that they just boss them around and they don't really want that either.

Accepting that "you can never be completely right all the time" while knowing that "you can always learn to make a better decision" from each experience is part of *being confident*. It means coming to terms with "not being perfect" and not making the "exact right" decision each and every time. Living "in an area that's kind of grey" in which "you could do this or that, which is better?" means learning to make a choice "without waffling," while being confident that the decision made will not cause harm to the patient.

Despite having confidence in most clinical situations, ACNPs nonetheless experience times and circumstances in which a sense of confidence eludes them. For example, others, particularly physicians, can still intimidate them. Additionally, there are specific clinical situations in which they doubt their ability to perform. One ACNP with over a decade of experience as a neonatal NP described how attending deliveries for newborns with meconium aspiration still fill her with self-doubt, making her uncomfortable, and apprehensive. This is not only evident in the words she uses in the retelling of her story but the defensiveness that the lack of confidence evokes.

> And you know it's in situations where you think that's a weakness of yourself perhaps, or somebody that can intimidate you. So I remember …I never like going to resuscitations where there's meconium because then you have to intubate their trachea in the case room. They're all slimy; it's completely uncontrolled conditions and things like that. And so I was called in the middle of the night to this delivery for this baby and everything that could go wrong went wrong. And I'm kind of that little - you know if I had to evaluate myself I would think I was not so sure of my skills in that area - so when everything went wrong and the physician who was there said, "What's your name?" [laughs] And you're there thinking, "Oh you're not happy with my performance, how long have you been doing this job?" [aggressive tone and laughs]. So yeah I wasn't very confident there. So I think in certain things…I think that that might be a weakness of mine, where you know, I'm not as confident. So it's easier to feel non-confident.

It is always easier to feel a lack of confidence than self-assurance, demonstrating the fragility of those feelings even over time and with multiple successful experiences. It appears that some degree of internal tension about being seen as expert by both self and others versus the lack of total certainty that this can be true always exists to varying degrees.

If you're trying to start an IV in a patient who is very difficult and then you've got the family watching you and you know they want you to get it right away, somebody's called you and your an expert and stuff like that but hey you just might not be able to get it, especially with somebody watching you. So sometimes you're not as confident. You know you've been brought in as this expert person that's going to get it straight away and that's just not necessarily going to happen.

When I Am In Doubt

When I am in doubt
I talk to surgeons.
I know they will know what to do.
They seem so sure.

Once I talked to a surgeon.
He said that when he is in doubt
He talks to priests.
Priests will know what to do.
Priests seem so sure.

Once I talked to a priest.
He said that when he is in doubt
He talks to God.

God will know what to do.
God seems so sure.

Once I talked to God.
He said that when he is in doubt
He thinks of me.
He says I will know what to do.

I seem so sure.
~ Glenn Colquhoun (2002) ~

Although these situations may not cause the same intensity or duration of doubt and apprehension as they did in the beginning of their practice and there is a willingness to acknowledge to others that they are unsure, ACNPs continue to work hard to reduce the gaps in clinical knowledge and skills that are continuously presented to them over time. This lack of confidence in their knowledge and/or skill abilities becomes both the compass for the need to know more and the impetus for continual learning and growth.

> Like I said, I'm kind of that knowledge person and I try to erase the deficiencies so that I do know what I'm talking about and I'm sure of it, so that I can be confident. It's when I'm not exactly sure. But then you know, I think as you do the role more and more then you just say, "you know, I'm not sure of this; I'm gonna go look this up and I'll get back to you." If it's something that doesn't require immediate decision-making I'll say, "Well I just read this and I can't recall the exact details but I'm going to go look it up and then I'll get back to you."

Therefore, *being confident* clinically is the belief that you know how to do something, that you have the power to make things happen, and that your efforts will be successful. *Being confident* is exhibited when ACNPs complete the task or skill and just "know" that they have done well. There is little doubt about the outcome of the performance. No external feedback is necessary to be convinced that the work has been executed or completed successfully. They just know. *Being confident* comes from knowing that knowledge, skill, and experience will result in success with confidence ironically being a key ingredient for that success. *Being confident* is related to performance; that is, *being confident* increases the likelihood of a task being accomplished well. *Being confident* enables the individual to make the most of the ability he/she has (Davidhizar, 1991, p. 105). Finally, *being confident* in one's competence makes *being comfortable* possible.

Being Comfortable

So for most things, I'm comfortable that I can make the right decision. And if I'm unsure there's always someone to call, always. You're never a boat alone in the ocean. It's somewhat like sailing around in a marina.

Being comfortable clinically is like feeling that one has finally come home. The word comfortable is derived from the Latin word *confortaire* and in its passive form means to be in a state of mental and physical ease, to be free from hardship, pain, and trouble (Barnhart, 1988). At home we are at ease, comfortable with ourselves; we are able to be who we truly are. Constituted in *being comfortable* are feelings of pleasure, enjoyment and even gladness. Indeed, the etymology of this word more than aptly applies to the account of *being comfortable* clinically as described by ACNPs.

Milan Kundera (1984) wrote that when existence seems to lose its substance, its weight, we feel "the unbearable lightness of being." Perhaps then, *being comfortable* is a weightiness of being that is experienced as a result of believing that one's practice finally has meaningful substance to it. As a consequence of *being competent* and *confident*, the weight of the practice is not burdensome but rather a source of deep satisfaction. In this state of *being comfortable*, uncertainty takes on a new meaning; that is, uncertainty is a taken-for-granted experience. As such, clinical problems are perceived as opportunities for being "stretched" and challenges to be faced with a sense of excitement. Although a sense of "awe," "wonder," or incredulity with discovering what they are capable of is now rarely experienced in their clinical practice, smooth sailing in the harbor is a preferred place to be at this point in their journey. The word "comfort" also means to strengthen (Barnhart, 1988). C*on* originates from *cum*, meaning together, and *fortis*, meaning to be strong. What are the forces whereby ACNPs can actually become stronger even as they live with the *dis-ease* of uncertainty in their practice? With whom is this made possible? Would ACNPs know the experience of *being comfortable* if they had not journeyed through the experience of *being adrift*? Is it not through *dis-ease* that they come to know something of ease or comfort?

Being comfortable can be seen as intricately and dynamically intertwined with *being competent* and *confident* clinically and should not be seen as a mutually exclusive experience of being. The knotted and entwined nature of competence, confidence, and comfort as experienced by the ACNPs is strongly evident in the introductory passage to this chapter. However, another brief passage is offered here to reinforce the interconnected nature of the three. An ACNP working in a paediatric neurosurgical specialty described her autonomously managed neurosurgical assessment clinic, which she had established after having recognized and affirmed her clinical competence with this patient population. Having confidence in her own competence, she felt comfortable to initiate an independent practice.

> And then a year later, I had gotten quite expert with these kids and I recommended to the neurosurgeons that I run a clinic for this [particular patient population], and that I would manage that clinic. And they went, "thank you, thank you.", [animated] So they just transferred all the kids to me. And so I run those clinics without needing the neurosurgeon. So I'm very, very happy. I see between four and five hundred children a year.

The recognition and trust that ACNPs receive from the physicians and nurses, along with their own multiple experiences over time, lead to both a desire and willingness to take on more responsibility independently. As noted earlier, giving the ACNPs responsibility occurs when they are seen as *being competent*. Taking responsibility is seen when they develop some confidence with their competence. *Being comfortable* means taking pleasure in having that responsibility.

Initially, *being comfortable* is experienced as a bodily perception that indicates ACNP practice is becoming easier. Due to a recognition of the more routine problems they encounter on a day to day basis, the mental fatigue caused by living in the moment-to-moment decision-making is no longer evident and in its place there is a taken-for-granted feeling that their clinical work is "second nature."

> I can remember being just so mentally tired from making these decisions and then I can remember **not** being tired. I can remember a call-shift and I wasn't tired and it was just so easy to make decisions. Not that they're always easy to make, but some are just easy. And so the easy ones were good. It was just a couple that were difficult, that you had to really think about. At that point [laughs] I was, "I can do this" [laughs lightheartedly].

Being comfortable means the responsibilities of clinical practice and the uncertainty of the outcomes of one's actions are experienced as less burdensome. Clinical practice is considered "manageable" and even "kind of exciting now," although a sense of responsibility never fully dissipates. As one ACNP with nearly six years of experience remarked, "It took me two years to get confidence and comfort to say 'yeah I made the right decision'; but there's still times now that I go, 'Well I hope I make the right decision'." ACNPs also feel less scared all the time, although here too, there is an acknowledgement that this feeling does not ever totally leave them. *Being comfortable* while living with augmented clinical responsibility and uncertainty is expressed in the following way by an ACNP with over 15 years of experience in this role:

> So I guess it took time to gain the confidence that you were making the right decisions and that you could make the decisions without the consultant. It took time for that to happen. Whereas I feel a lot more comfortable now. I mean with experience, the years that have gone by, the confidence that the surgeons have in me and people have in me, I'm able to make decisions without too much concern or question.... [But] it doesn't matter if it's the beginning of the role or the end of the role, things happen and you're stressed, and you have difficulties sleeping, you worry about something. You're thinking maybe you should have done this. And that can happen any time. But I think I've become fairly laid back. I don't get too, too stressed by things as I did before.

As fatigue and mental exhaustion disappear with the establishment of knowing how to clinically care for the patients in this role, and having settled into a "lull" or routine in terms of process, systems, and patterns of communication, the opportunity to enjoy learning begins to resurface. What once was experienced as "scary" is now perceived as "exciting" and "fun." A critical care NP expressed this reuniting of her love of learning with the excitement of facing a new challenge.

> So over the course of the last [six years], I mean it's always an ongoing, I mean there's something you can learn every day, and one of the physicians I work with says, "You know it's a good day if you've actually learned something new," and I think every day is like that for me when I'm working in there. And so it doesn't stagnate; I don't get bored with my job because there's always something new that's coming, and with nursing, and medicine, health care in general, it's always changing. You know the environment is changing and what might be in today might not be in tomorrow. And even in the field of cardiac surgery in this new era of stenting and the cath lab and between multiple procedures in the cath lab and stuff, it's changing the environment of surgery because now we're not getting those easy ones that we used to get and we're getting all the ones that they've tried everything else on for the last ten years and now here they are kind of thing. So just adjusting to new operative types of procedures which we're doing and just all of that kind of stuff. It's exciting now; it was scary then.

In fact, once knowledge and skills have been "honed," some ACNPs "hanker after" more challenging clinical situations, wanting to continue to push the boundaries of their abilities. This sense of wanting to be stretched re-emerges as an aspect of *being comfortable* clinically. Another ACNP described the excitement and adrenalin rush she feels when she is faced with challenging situations that she is able to manage autonomously. The following passage describes her love of working off-hour shifts because of the opportunity it affords her to autonomously manage the patients clinically. *Being confident* with her abilities to assess and intervene in the more routine problems in her patient population, the ACNP described that now that the "the scary stuff was gone," she "could move in more easily" for those emergency care procedures, "knowing and trusting" her instincts and skills. Feeling scared is no longer a state of being in *being comfortable*, but rather is accepted as an integral part of the excitement of risk taking. A line in Coelho's (1988/1993), *The Alchemist*, the journey of a young shepherd boy, in quest of worldly goods, expresses this feeling: "A shepherd takes his chances with wolves and with drought, and that's what makes a shepherd's life exciting" (p. 13).

> *[He] had learned what it meant to leap into the void and [plotting a meticulous route on the nautical chart] had been a source of satisfaction in a profession where accomplishing safe passage between two points situated at far-spread geographical latitudes and longitudes was essential. There were few pleasures comparable to deliberating over calculations of course, drift, and speed, or predicting that such and such a cape, or this or that lighthouse, would come into view two days later at six in the morning and at approximately thirty degrees off the port bow, then waiting at that hour by a gunnel slick with early-morning dew, binoculars to your eyes, until you see, at exactly the predicted place, the gray silhouette or the intermittent light that – once the frequency of flashes or occultations is measured by chronometer - confirms the precision of those assessments. When that moment came, he always allowed himself an internal smile, serene and satisfied. Taking pleasure in the confirmation of the certainty achieved through mathematics, the on-board instruments, and his professional competence, he would prop himself in one corner of the bridge, near the mute shadow of the helmsman, content that he was on a good ship, rather than in that other, uncomfortable world,*

> There's exciting aspects, I love doing the night call. I mean, I don't like having the potential to be awake all night but the job changes when you're on nights and that's because you have a more independent function during the night. There's not as many people available so it really forces you to hone your decision-making skills and it puts you really in the driver's seat that night, and you've got to make the decisions and you have to be comfortable with it. And those first couple of years, there are many times when you're thinking - this is kind of scary. It's not that the buck stops here, but it becomes kind of more major if you have to call the [attending physician] and he has to come in from home or something. So it does seem a bit scary that you're more responsible for decisions, there isn't a whole team of people around you. And I really enjoy that; I like that.

now reduced by good fortune to a faint
radiance beyond the horizon.
~ Perez-Reverte, 2001, pp. 33-34

A fascinating aspect about the development of ACNP confidence and competence is the ability for confidence and competence to create a taken-for-granted sense of comfort within the team, which then fosters a synergy between the ACNP and team members. Not only is the ACNP becoming more efficient and effective as an individual practitioner but, as a result, the team becomes more efficient and effective too. Subsequently, a sense of comfort arises such that the ACNP and team members no longer think about the momentum of the day. This sense that a service or program runs itself infers that the team members know the expectations of each other as well as of themselves in relation to the other(s). They are able to trust each other and respond to each other in a synergistic manner, each coming together in the enactment of their practice only to be strengthened. Each knows what needs to be done and who will do what aspects of the care required. They trust that each member knows how to do what is required of them, in the performance level expected. As they become comfortable with each other, ACNPs become more comfortable with themselves in this role. Thus, *being comfortable* helps to sustain the developing sense of who they are as ACNPs. This sense of comfort intertwined with competence and confidence as experienced by the ACNP and the entire team is reflected here by an ACNP working in an oncology specialty.

> And I think it's less dramatic now that I've been there for awhile, or maybe I just don't see it as much anymore, or maybe ....now I think we've settled into a lull. It's not that I'm not as valued as I was at the beginning, but just that it's settled into a good system, and I prefer it like this. I don't like people always being happy that I'm there. It's nice now; it's just comfortable, to the point where like my boss would now say if I'm out of town, people don't know why he's come to do the bone marrow instead of me, like they're, "Like what are you doing here?" because they expect me to be there...It's now more taken for granted....Like now it feels like our team runs like a well-oiled machine and ... nursing is very much a part of that running of a well-oiled machine, to the point where we don't wonder why things run so well anymore because they just do.

Settling into a routine also helps ACNPs create boundaries to their scope of practice. Ironically, when feelings of *dis*-ease now arise, the ACNP is informed that these boundaries have been breached, indicating assistance is needed. Perhaps *being comfortable* must always lie in the shadow of *dis-ease*, but as a consequence, *being comfortable* serves both as a compass and an internal safety line.

> It's knowing when you're out of your comfort zone and it's that extra ten percent that you need to know that you can't handle and you've got to find somebody who has that additional training, who has that additional knowledge. ... I mean 80 to 90 percent of

> medicine is pretty routine and the nurse practitioner is more than able to do it, but knowing that extra 10 percent is very important in the life of a patient.

A "comfort zone" is the internal place where feeling at ease is experienced, which results from being able to engage in their work in a way that requires less effort and distress. *Being comfortable* means that the awareness of uncertainty fades from their every day awareness. Uncertainty (and dealing with it) gradually becomes integrated into their lives such that it no longer requires active management, nor is it experienced as solely distressing. Uncertainty, rather, is perceived in a new light. Uncertainty is integrated into their being, having evolved from what was once a catalyst during the time of *being adrift* into an outlook that requires less conscious reinforcement. Uncertainty has gradually evolved into a certainty in one's own strength and resilience. This sense of certainty is an element of *being comfortable*. This transition has been strongly influenced by the development of competence and confidence, the results of which have been an exhibition of increasing certainty in their decision-making related to the clinical management of those patients for whom they routinely care. Certainty is encouraged by physicians; they are quick to admonish when too much unsureness is displayed, indicating that doubt will impair their effectiveness with patients. In fact, it has been suggested by Katz (1984) that this medical socialization involves *training for certainty*, not uncertainty (p. 184-206).

Ironically, *being comfortable* also means that ACNPs realize that many of the decisions they make are not white or black, good or bad choices that result in either life or death. They learn that there is a wide and open grey area, an area of differences of opinion and a variety of choices that can lead to the same outcome. Some choices may be better than others, but not all choices are wrong or bad. Although this helps to diminish the fear associated with the responsibility of clinical decision-making, it creates a taken-for-granted lived tension between certainty and uncertainty. As one ACNP stated as she described living with the responsibility of clinical decision-making for children with cancer:

> Yet as I'm sitting here, I know the more I learn about that those decisions, I realize that there's no right or wrong either, and as I'm learning more, I guess I'll throw it all in the hat and pick one out too. It's like the more you learn the less you know. ... So what I might fear because I somehow think that it's life and death, really it isn't, and the one course of chemo, if I made a mistake on it, it's not as bad as I feared. I don't know. It's weird stuff. It's not as an exact science as you think it is.

The reality of needing to initiate a plan of care and some treatment interventions before all the definitive information is available contributes to this understanding that choice(s) made may be less than perfect or even wrong. But *being confident* and *competent* facilitates *being comfortable* in taking the risk to make clinical decisions based on limited information and the inexactness of medicine.

> So much of what you do initially is based on scanty information, but you have to take that scanty information and try to say okay what could be the problem with these symptoms and then as you're working, okay it could be this and this and this, so what will I need, what more information will I need to tell me that it's this first problem? Would it maybe be electrolytes, or something else will tell me it's more likely to be that. And then even in the end you may not have enough information to say for certainty, ... so you have to just take this limited amount of information and say, I think it's this, this or this. And then how are we going to manage each one? Maybe there's conflicting ways to treat them so you're going to have to make a decision, well I really think it's this. And I mean you're going to be wrong sometimes but other times it's kind of where the clinical and the laboratory and diagnostic information leads you and the patient, and it kind of changes.

Being comfortable ultimately means living with the responsibility of caring for fragile and vulnerable patients knowing that the choices they make can result in harm and even death due to the certainty of their imperfection. Patient outcomes are less than certain and imperfection in clinical decision-making accentuates this uncertainty. It is apparent that an inherent aspect of *being comfortable* is also about having learned to live with the internal struggle to be perfect in the direct clinical practice component of their role. This is brought forth in the following two ACNPs' words.

> I definitely am not perfect, and that took me a while to figure that out, that whole perfection thing, because I am a perfectionist, to recognize the fact that I'm not perfect, as I said, that I do make, everybody makes mistakes, or may make an error in clinical judgment.

> But also to recognize if you didn't make the **exact right** [emphasized each word slowly] decision, you may have made a little bit of an error, not something that's life threatening. ... I guess recognize that you can't be perfect. This job makes you realize that. And that you can be humble because if you **think** that you know everything and that you are always right, you won't survive, because we all make errors, like we all may make not exactly the best decision at the time, and you have to deal with that.

ACNPs are the first to acknowledge that they do not have the same breadth and depth of knowledge as the physicians. Yet they are also quick to acknowledge that medical knowledge itself falls short, a lesson first learned as a bedside nurse and then further solidified as an ACNP. Medicine is "not an exact science," as previously noted, "because we don't really know anything, really", "we just know that that kind of worked for that." Working in health care is always filled with uncertainty. But *being comfortable* means that ACNPs, because of the lived experience of *being competent* and *confident*, are able to distinguish between their own lack of skills and knowledge and the limitations of present knowledge. *Being comfortable* means that a balance is found between being sufficiently decisive, certain, and in control, while recognizing the uncertainty that abounds in what they do. It does not mean they wear what Katz (1984) has referred to as the medical "mask of infallibility" (p. 198) so often demonstrated by physicians.

On the one hand the tension between uncertainty and certainty leads them to continuously strive to provide the best quality of care they can deliver by reflecting on their mistakes, by never taking the decisions they make for granted, by asking for help when necessary, by knowing when they are outside their scope of practice, and by reducing the knowledge and skill gap through constant learning. On the other hand, they come to terms with their need to be perfect, for without doing so, they either stifle their own practice opportunities and prevent timely responses to patient care and/or they live with the constant anxiety that not being able to be perfect brings to bear.

> And some of us deal with it very well; others of us get way too uptight about it and it doesn't benefit our families for us to be so constricted that really we're not working at the NP level but we're still at the bedside level. Or the other issue is to become so blasé about it that you just think oh well it'll all work out in the wash and then something happens and it doesn't.

Anna Quindlen (2005) wrote, "perfection is static, even boring" (p. 39). Even the need to create an aura of perfection, of knowing it all, this effortless perfection, the mystique that is often associated with the medical perfection, finally gives way. Obviously effortless perfection is an oxymoron. Even the illusion of perfection requires an enormous amount of work. This is part of the fatigue or sense of exhaustion that the new ACNPs feel when they are working at trying to prove to others and to themselves that they can do this job. It helps to explain why at the end of a day of trying to be perfect they always feel so exhausted. By elevating medical perfection to a high art it eventually becomes "like carrying a backpack filled with bricks every single day" (Quindlen, p.11).

Trying to be perfect may be inevitable for people who are smart, ambitious, and trying to be the best they can be, always wanting and needing to be challenged and stretched. Trying to be perfect may also be inevitable in a profession that carries the worry of causing harm to others for whom they care. But what is really difficult, and really amazing, is the ability that ACNPs have to let go of the idea of being perfect and begin to work at becoming themselves once again while performing in this role. Letting go of trying to be perfect is difficult because it means that maybe others will see that they don't know what to do all of the time in the clinical management of the patient. Maybe this will result in others rejecting or replacing them, both as an individual and/or as a practicing group. But it is also amazing because letting go frees them from having to work so hard all the time to pretend they know it all or can know everything concerning their clinical practice. Ironically, letting go of trying to be perfect also frees them to accept more responsibility and to undertake more risks, which when successful, brings about even more rewards of self-confidence and comfort. The tension with which the ACNPs live is also accentuated for two more reasons. First, there is no ACNP zeitgeist to guide them. Second, their previous grounding in a nursing moral imperative necessitates that they reject the mask of infallibility and eventually let go of the "medical mask" that they were compelled to put on as part of proving that they were clinically competent. *Being comfortable* as constituted in learning to live with the tension of certainty and uncertainty is found in the following passage.

> [Responsibility] can be exhilarating at times and it can be [pause] almost disabling at times, because all it takes is one instance for you to second guess yourself, to say, should I have done something different, would I have done something different if I had known this or that or the next thing, or a physician to say to you, "well did you think about such and such," and to think, well yeah I did but I discounted it; but should I have thought about it more? To think, oh my goodness, this is too much; I'm not a physician, I shouldn't be doing this; this is way outside the scope of practice, when in actual fact it's your own sense of well being and your own sense of perfection that's getting in the way of that. And then to be able to say - no, I did the best for this child and this is how it worked out and maybe it's not what anybody else wanted but this is how it worked out. And I think those kinds of moments make you think - okay I just want another job; I just want to be doing something else, I don't want to be doing this. But then, you know all it takes is one of those families to turn around and say, I'm so glad that you're on the other end of the phone and that you could answer my question, and that says - okay, that's enough to negate. And you learn those lessons, you learn from those areas where you had some doubt and where you think okay now I'm going to do such and such and such and such and spend some time looking at those things. And then other times you just have to say you know bad things happen. You just have to go on with practice not because you did anything to make that bad thing happen but unfortunately bad things still happen to children with heart disease just as bad things happen to anybody. Some of those things just happen and you didn't, in all of your ego, have as big an impact upon the outcome as you thought you did.

Although *being comfortable* means that uncertainty is generally a taken-for-granted experience on a day to day basis, various circumstances, such as having to deal with a new clinical event or a change in the medical team, particularly the loss of a trusted physician or the addition of a new member, brings uncertainty into full awareness, with the full range of emotions that this evokes. One need only recall the earlier illustration of the ACNP who was in the process of re-negotiating the boundaries of her scope of practice related to tracheostomy changes to realize the *dis*-ease or tension this re-awareness of uncertainty brings forth. In another example, one ACNP describes the surfacing sense of *dis*-ease that came about with a change in medical directors in her service. She was once again faced with the awareness of uncertainty as to how she would acquire her patients, the population to whom she would be assigned, and the expectations regarding her role under the new medical management. However, what is also beautifully revealed within this narrative is the discovery that this *dis*-ease, which results from uncertainty, is also embedded in *being comfortable* with her own clinical competence and confidence. She feels a sense of certainty that she will eventually be able to negotiate her way through this situation to the satisfaction of the patients/families, the physician, and herself. One feels her sense of relaxation with the negotiation process and the timing it requires, as well her patience and adaptability to the clinical situation, which can only be displayed when one embodies *being comfortable*, *confident*, and *competent*.

> With our previous medical director I was very comfortable with how I acquired my patients and whether I kept them or not. This current cardiologist is brand new to the system; he's brand new to practice, and so he and I have a few bugs to work out yet. ...With the previous medical director if I said to him, "Well you know this family has these issues," he would say, "Do you want to take them on and I'll see them in your clinic time?" whereas this particular cardiologist doesn't necessarily like to be there during my clinic time, which is a bit difficult, because I think then he would have been more comfortable with me keeping more of what he classifies as the complex patients. And so I think it's always a negotiation process and it is with any physician that you add in. We had at one point three full time cardiologists and one part time and each one of them was a bit different in terms of what they wanted you to do for them and so forth. So I think really, the NP role has to complement the physician role, not so much that we're subservient to them or beneath them, but we have to each be comfortable with each other's care and what we can and can't do. And so I think in any given instance there's always a negotiation process. So for right now he wants children with left over fetal circulation, he needs those patients seen, but he doesn't want to see them because they're not exciting and they're not good teaching cases, and so now we're going to do a bit of a switch. And he says, "Well those patients need to get seen but I want your surgical patients and you take those routine non surgical cases." So I think we'll do a bit of negotiation over the next couple of months in order to get that worked out because my background is surgery, that's how I started as an NP was to do cardiovascular surgery, and so I don't want the families to loose my expertise for them, because they need the time and they need the expertise of somebody who's been in the operating room, who knows what the repair looks like, who can tell them what the post operative period is going to look like; they need those questions answered. They're not going to get that from the cardiologist and so I think you know there will be some negotiation over time as to how that happens.

An awareness of uncertainty also arises when ACNPs are forced to acknowledge the tenuous nature of the medical safety line. As explored in *Being Adrift*, the presence of a safety line is integral to the clinical practice of NPs working in acute care. As the following illustration reveals, a crisis of confidence in this line brings about an awareness of uncertainty so powerful that it brings into question the entire foundation of ACNPs' clinical practice and their ability to function with any degree of comfort as NPs. If the ACNP cannot trust their physician colleagues, they are unable to trust the decisions they themselves make and consequently question the ethical nature of the practice they provide. Being comfortable and confident in other's competence is a two-way, not one-way, experience. At one level, this crisis is not dissimilar to that described by Benner et al. (1996) at the stage when the competent nurse learns experientially that both experienced nurses and physicians make faulty assessments or treatment orders that undermine their confidence about the authority of these colleagues. As Benner et al. contended, "in reality, these nurses are confronting both incompetency in some coworkers and a necessary correction of their inflated expectations of experienced staff" (p. 101). But at another level, there is a significant difference, a difference that relates to the degree of responsibility with which the ACNPs live. ACNPs often do not make the initial primary admitting medical diagnosis in the acute care setting, yet they carry the responsibility for ordering the necessary treatments associated with it. Their role in the patient's outcome is therefore both more attributable and visible, as they set into motion a set of prescribed activities that will either help or harm the patient. In point of fact, there is a sense of culpability of not only being guilty by association, but even worse, a feeling of being an accessory to the crime of the poor performance of their medical colleagues. Hence, they are dependent on the right diagnoses being ascribed. In other words, they are reliant on the competence of their medical partners and the physician's willingness to engage in self-reflective practice and to make personal and/or system changes to decrease patient risk and to promote safe practice. Physicians have repeatedly expressed their concerns about potentially being held liable for ACNP errors in practice. The question arises, should this not be a reciprocal concern for ACNPs?

In the following illustration, the ACNP shares her experience of having discovered first hand the fragile and illusionary nature of her safety line. She is once again living with the awareness of uncertainty in her practice on a daily basis, despite having developed a strong sense of confidence and competence in her own abilities that are associated with her scope of practice. As a result of her profound *dis*-ease, she reveals that she is experiencing a breakdown in the meanings that constitute and sustain her practice as an ACNP. In other words, she no longer experiences this weightiness of being that is *being comfortable* clinically. She questions if she has made the right career choice in becoming an ACNP. Her work no longer makes sense to her and she is considering other options. Her disillusionment is not attributed to a naivety about the infallibilities of herself or others; she is not seeking perfection for herself or others.

What this ACNP's story demonstrates is the profound tension that is felt when ACNPs are again confronted with the stark realities of their own vulnerability within their practice. This illustration serves as a reminder of the persistent awareness of existential uncertainty that being in the ACNP role introduces into their lives, as well as its tenuous nature. It had taken this ACNP "nearly five years" to reach the point where she could say, "this is a bit routine, I am feeling comfortable with this aspect," but only a split second to lose it. This ACNP's story supports Cohen's (1995) theory that particular triggers can heighten the awareness of uncertainty and cause ACNPs to question whether the work demands are worth the personal cost. It also demonstrates how a loss of *being comfortable* due to the resurfacing of the awareness of uncertainty as experienced through engaging in action with one's community of practice is closely linked with the ACNPs' identity. This ACNP explained her "need to take a break" from the "NP hat" (component) of her role "because there'd been a few scary incidents" related to patient safety. Furthermore, the physicians had "buried their heads in the sand." Although she acknowledged that "you can never guarantee" that a "mistake won't happen again," she had an expectation that everyone "think about it and try and put into place the changes that are needed to hopefully assure that this kind of thing won't happen again." An internal battle involving the social and ethical nature of her work is revealed in this illustration. At this point in her journey she is experiencing difficulty in reconciling the form of membership she has with her medical colleagues and consequently is struggling with who she is when wearing the "NP hat."

> I verified with the doctor in the clinic that day that this was in fact the right protocol that this [patient] should be on, and you know reviewed the orders. ... Anyway for whatever reason, I did his history and physical but I didn't end up signing the orders because the physician I was working with that day had waived the platelet count and said we're going to start the treatment even though his platelets are too low for this protocol, so I'll sign that, and then she proceeded to sign the rest of the orders, and [the patient] was admitted. Well low and behold the next day the [physician] who had picked that protocol realized that it was the wrong protocol, and in fact [this patient] could die if we continued to give him this treatment. .... And you know, I almost died as well because I had seen [the patient] in the clinic that day and regardless of whether or not I had signed those orders - I hadn't been the individual to sign the orders, although that was definitely a factor - a feeling like what's going on here? Like can I not trust my colleagues here, my physician colleagues, to pick a proper protocol? I almost signed those orders. If that [patient] had died from this protocol, like my name is on those orders. I don't want to lose my nursing license over a situation like this, and probably more importantly I feel that, I felt at the time that, like you have to be able to look a patient in the eye and have them feel that they can trust you. And that was starting to waiver for me. I felt like I couldn't [pause]. I wasn't sure of myself anymore, or my colleagues in terms of their ability to pick and choose the proper protocol,... and it just came to a crisis for me. I'm like a sitting duck sitting here in the clinic signing orders that potentially are not the right orders, if you know what I mean. And so it kind of tipped the balance for me at that point in terms of the NP role and thinking that I'm not sure that I like this role anymore, and what I'm doing in it, you know, parts of it anyway. And where do I want to go? What do I need to do to feel comfortable going to work every day? What is my role in relation to all those protocols? Certainly I have to know them, you know. I'm signing. If I'm going to be signing orders and admitting [patients] under protocols I have a responsibility to know those protocols, right? But I don't pick the protocol either, you know. That's the physician's point. And I'm just trying to sort through all of that in my own head right now. So, some of that - what I do in the NP role? - I'm not sure about anymore. ... And

> right now I'm feeling overwhelmed with [the responsibility] to be honest. It hasn't always been that way though, and … I am very much a team player and feel like I need to be able to trust my colleagues and work with them. And I think that's how a team functions, right. If it's not functioning you're in trouble. … But I think I felt supported to a certain degree in doing what I was doing and, you know, always knowing that there would be a medical practitioner right next to me who, if I felt out of my realm, I could turn to and ask questions of and can trust and you work as a team with people. I guess it's just now where I'm coming to a point where I feel that I'm wondering if I - and I'm not perfect, I'm not saying I'm perfect either, we all make mistakes - but I'm feeling the weight of that responsibility and feeling like what if I can't trust everybody on this team? What if there is one individual or whatever who I'm having some concerns about in terms of their practice and how they pick and choose protocols and whatever in the thoroughness of their work? And so I'm thinking I don't want to lose my license over something like this, you know, because that part of it isn't nursing, right; that's sort of the medical piece that I've taken on.

In understanding what it means for ACNPs to lose their safety line, consider Pi Patel's experience of surviving a storm at sea only to come face-to-face with the loss of his life raft in Yann Martel's (2002) *Life of Pi*.

> I noticed the loss of the raft at dawn. All that was left of it were two tiered oars and the life jacket between them. They had the same effect on me as the last standing beam of a burnt-down house would have on a householder. I turned and scrutinized every quarter of the horizon. Nothing. My little marine town had vanished. That the sea anchors, miraculously, were not lost – they continued to tug at the lifeboat faithfully – was a consolation that had no effect. The loss of the raft was perhaps not fatal to my body, but it felt fatal to my spirits. (p. 253)

These illustrations are not dissimilar in many ways to the one presented earlier in this chapter related to the ACNP who found herself in new and uncharted territories as an expert in the performance of lumbar punctures. The ACNP experienced a crisis related to the uncertainty she felt when she realized that her skills had surpassed those of her physician colleague, while at the same time still needing his support. Awareness of uncertainty arose because she suddenly realized that she was outside familiar territory without the requisite knowledge required to legally engage in the activity. At the same time she recognized that her expertise might be what was right for the patient in that particular situation, although not best for her. However, the sustained sense of certainty in the safety line is a fundamental difference that is brought to light in these two illustrations. The ACNP in this latter situation related that she felt a strong sense of relief when she "saw [the physician's] face outside the door" and realized that "he was going to back [her] up." This relief reveals the uncertainty she must have experienced, even if only momentarily. She also illuminated the "faith" or confidence that ACNPs have in the presence of the safety line. As she acknowledged, "the fact that he came down, that sort of refreshed my faith in him."

This example reinforces that *being comfortable* for ACNPs means being strengthened by the “true” presence of others for the purpose of enhancing their well-being in clinical practice. The physician’s presence helped the ACNP to overcome her *dis-ease* (at least for the moment) by providing a sense of being heard, a moment of being together, of not being alone in this difficult situation. As a result, she was able to re-experience a sense of well-being, or as Buytendijk (1961) eloquently wrote, “the stream of life within us seems renewed or strengthened” (p. 21). In contrast, the ACNP in the former situation is experiencing a crisis of faith in the foundations of the safety line and consequently lives daily with the awareness of uncertainty about the clinical management of the patients for whose care she has been entrusted. This ACNP’s uncertainty comes from being confronted by the limits of the collegial relationship on which she is dependent, the failure of the safety line, combined with the limits of her own knowledge within her practice.

Being comfortable emerges when certainty is perceived as an inner state of confidence and competence in the clinical management of the patients. *Dis-ease* is the awareness of uncertainty that is attributable to outside forces, that is, to those who potentially or actually impact negatively on the ACNPs’ work. This awareness results in a felt sense of responsibility for having caused actual or potential harm to their patients, what Cassell (1987/1992) has called “paranoia” in her study of surgeons. Is it possible that the more *dis-ease* some ACNPs’ feel as a result of a sudden awareness of uncertainty, the more likely they are to publicly project these feelings onto others in a disparaging way, not unlike surgeons? Is it possible that this is one outcome of becoming visible? For ACNPs, the outcome of a clinical event, whether positive or negative, is now visible, in that it occurs before an audience. The outcome is now attributable to them; both the ACNP and patient know who is responsible. Certainly, Cassell attributed these two factors to why surgeons are so aggressive not only in what they do but also in how they interact with others, particularly when it involves actual or potential errors.

In the following passage, an ACNP describes her reaction to a near miss encounter that occurred during an operative procedure that she was performing. Although she recognized that her reaction to the nurse’s error was possibly overly excessive and hurtful, she also revealed the fear and doubt she experienced when she was suddenly faced with the depth and magnitude of the responsibility she carries and the lack of certainty that she would never make a mistake. She was made aware, particularly in a public venue (the operating room), that she could possibly have perpetuated the mistake of another, which would have resulted in the patient's death. Not negating the influence of individual temperaments, perhaps the need to make "the incompetence" of the nurse visible was also in part due to the performative aspects of the ACNPs' work as they have now come to live it. Now that the outcomes of the ACNPs' actions are both more attributable and visible, perhaps there is a need by some to critically judge others publicly. "The public glory of victory is balanced by the fear – and shame – of public defeat" (Cassell, p. 181).

> We had a new nurse who thought she was being helpful, and came and delivered the drug that's being given to the operating room to me; and I was just about to start the spinal and she came running in the room and said, "you forgot the Vincristine upstairs", handed it to me, and I just **glared** at her. And I don't think I'm really a mean person, but she just started to ball, she just started to cry and cry, that's how I looked at her, because that's the drug that's killed all the kids, and she brought it down. I had one of the nurses in the room call upstairs to warn everybody that she was on her way back upstairs, because I didn't even say anything. But however I looked at her was enough for her to just melt into tears and start crying because she was handing me a drug that I would have given that would have killed the child. I mean hopefully I would have checked it and I would never have given it but just that, like that tells you how, like the **fear** and the [long pause]. Like I said, I don't know how I looked but whatever it was made her cry. But I guess it's similar to what I was saying before, that I give it every single day, and I'm glad it's me and I'm glad it's not her [laughs], and I'm glad it's not any resident, and I would never let a resident do it, ever, and I would never let just any family doctor that's coming through the service go down to give it, because I know what I'm doing, and I know that I'm giving the right drug into that child's spine every day, because I do it every day.... And I guess it was her incompetence was the look I probably gave her and that you shouted your incompetence out loud in this room. I guess that was probably the look I must have given her, especially because I already had the drug to give in the room already, I mean I was just about to deliver it. What we do as a last final check in the room, is we read it out loud - that's one of the Canadian rules, we have it marked on it to be delivered intrathecally - I read it out loud, the child's name to the anesthesiologist just before opening it and putting it on the tray and just before giving it. So this poor girl walks in, "You forgot the Vincristine." Bless her heart. Like I'll never forget that image of her face.

Indeed, *being comfortable* for ACNPs means being strengthened through ably doing, acting in association with a trustworthy safety line, and being recognized by others for their abilities. But as these illustrations have revealed, ACNPs must also perceive a fit between their expectations for clinical practice as an ACNP and those of others, not just in terms of clinical competence, but also in terms of the type of practice in which they wish to engage. ACNPs convey *being comfortable* through such words as "being excited," "having fun," "being satisfied," "feeling safe," "being happy," and "having found the perfect fit." All these expressions show *being comfortable* as an affirmation of the positive values concealed in the practice of being ACNPs. How ACNPs embody their practice is as important as what they "do" in their practice. It is here that having found the right fit as it relates to clinical practice becomes evident in *being comfortable*, a fit that is associated with *being committed* and *connected*. At home in their practice, feeling most like themselves, they are able to relate to others in the way that is most meaningful to them and in a way they experience as making a difference. What differences do ACNPs make in their clinical practice? This is revealed in *being committed* and *being connected*.

Being Committed

As ACNPs gradually become clinically competent and confident, they find themselves able to advance the tenets of nursing caring into their clinical practice. This in turn enhances *being comfortable* and we are further reminded of the co-experienced and complex nature of the various threads of *being an ACNP*. Acting skillfully, being present in the moment with the patient and/or family, listening, providing information, reassuring, and explaining, as well as exploring the meaning of the illness event with the patient and family, are revealed as integral to their practice and to their sense of identity as ACNPs. ACNPs are committed to the personalized care of the patient and their families, which is enhanced by *being competent*, *confident*, and *comfortable*. *Being committed* is evident in the neonatal ACNP's desire to be inclusive of the family at the patient's bedside when performing the admission procedure and the orthopedic ACNP's patient teaching and exploration of home conditions prior to surgery.

The word commit derives from the Latin word *committere*, *com*, meaning to join with, and *mittere*, meaning to send, as on a *mission* in the form of a function or service, or in a form manifest to humankind (Barnhart, 1988). In this light, *being committed* means that ACNPs are entrusted or charged with the safe keeping of those for whom they care. In so doing, they must connect themselves to Others, and by implication, dedicate themselves morally to their cause. *Being committed* and *being connected* then become interrelated in their practice, and although regarded as discrete entities for writing purposes, they are co-experienced, along with *being competent* clinically, *confident*, and *comfortable*.

Being committed speaks to the desire to care for each patient and family to her or his best ability in a way that is morally responsible. *Being committed* is about providing ethical care by "being *with*" others in the moment in a context of "doing *for*" within their clinical practice and is an expression of their caring as nurses. *Being committed* is strongly demonstrated in the intentionality of their actions, in the meaningful and purposeful attendance to the particular and personalized care of the patients and their families in the moment to moment. Indeed, throughout the ACNPs' narratives there is a strong sense of commitment, or responsibility and accountability to the Other. Commitment is "a decision, a choice, every day, even when it is really difficult" says Jackie Harrison, Susan Sarandon's character in *Stepmom* (Finerman, Columbus, Radcliffe, & Barnathan, 1998). It is an act of will to do what is believed to be right and good in each moment, in every situation, despite the risks or burden. Commitment is best expressed in Rainer Maria Rilke's (1975) words, "If only we arrange our life according to that principle which counsels us that we must always hold to the difficult, then that which now still seems to us the most alien will become what we most trust and find most faithful" (p. 99). But how does *being committed* manifest itself in ACNP practice and what meaning does it hold for them?

Being committed as a core thread of *Being an ACNP* is revealed in the ACNPs' experiences and stories to mean being caring through the act of being technologically competent. Nightingale (as cited in Johnson, 1994) wrote that "the artful nurse knows more than what is to be done; she knows 'how to do it'" (p.7). Being technically skillful as one component of being technically competent is a matter of pride for many ACNPs and in acute care institutions it is most often an expectation of the role. "Well from the nurses' point of view, I mean you're expected to be competent in the skills they want you to do," said an ACNP working in a critical care area. Another participant from an inpatient unit added, "You should be able to get IVs when nobody else can."

> Well I do like the doing things, doing procedures. I do. It sounds like I'm bragging but I'm very skilled at the clinical, extremely skilled. And even though sometimes I'm kind of a bit scared inside or you know things are happening, I don't project that. And the nurses have all told me that they really like working with me because, well, I guess they think I'm unflappable [laughs]. It's like, you know, you just project this calm experience and you've got to kind of deal with things when they come up. And yeah, I can do things I guess.

As revealed earlier, the ability to skillfully perform is primarily judged by self and others by focusing on the process of doing – in terms of such criteria as proficiency, efficiency, and fluidity (Johnson). But there is a knowing and responding with intentionality to the patients as whole in the particular situation that ACNPs bring to the activity for which there has been little or no appreciation in the literature. Why is this? Do we fail to see and/or reveal it because technology as care is not valued?

At one level, being "really good" at these skills is about technical mastery and receiving immediate gratification for a job well done. The reward of having achieved the desired outcome(s) in a way that everything is made to look easy and with a natural kind of rhythm, speed, and flow is a strong source of satisfaction. Positive feedback comes in a variety of forms, everything from being recognized by one's' colleagues as expert to being personally sought after by patients and/or families to perform the procedure. This feedback enhances *being confident* and *comfortable*. One can also not deny the heady source of pride they feel when they hear from patients or families that it was their skill that "saved" their lives. This is tangible evidence that one has made a difference. For some ACNPs, being technically proficient is about being in control, being able to take action, however risky, rather than standing by and waiting for others to act. For a few ACNPs, although by no means all of them, there is also a "love for doing skills;" there is a natural fondness for it. The adrenalin rush that comes from having successfully engaged in technical procedures where the intensity is high as a result of the high risks associated with failure is at once terrifying and addicting.

> I love going to the case room and do those things, do the kind of initial resuscitation. Some people say it's the adrenalin rush, so those kinds of things, yeah I go for that. ... Yeah, you're terrified a lot of the time. But when you get it, it's like, "oh, I did it, I accomplished it. It's great. This is such a great day, I did this and this."

In the following passage, one ACNP's thoughts reveal that the rewards from "doing procedures" are immediate; the victory is rapid, definitive, and ascribable. In a profession where external rewards are few and value for what nurses do is generally unacknowledged and even credited to the medical profession, one can readily appreciate why the immediacy and visibility of the success of "doing procedures" is so satisfying. This ACNP had stated that the "hope of doing technical, advanced techniques" was one factor that had initially drawn her to critical care nursing and then to the ACNP role. When asked to talk more about "this draw" to "doing procedures," she responded:

> What is it about it? I think it's a very concrete thing in nursing. You know, getting the satisfaction from the parents and stuff like that - sometimes you get it in a very concrete way in the sense that the parents will say, "Thank you very much, I appreciate the work you did with us." Overall though that's more a minority of parents; that's something that you feel within, you feel that they were satisfied with your service. I mean ICU is a very stressful place and I think people just don't think about it. They're just happy to get out of here. ... So that's one thing where you do get some rewards, but it's a bit more subtle. Where with technique, you go to put in an IV, you take that catheter, you put it in, it's in; that's the immediate reward. And I think in nursing we don't have that many immediate rewards. So the techniques I think is, it's challenging, it's sometimes difficult, but yet it's very rewarding, and in a very immediate way.

The significance of the instrumental nature of the role itself as a means to visibility is also revealed in the following ACNP's thoughts. She shares how satisfying it has been for her to be able to perform percutaneous intravenous central catheter (PICC) insertions throughout the hospital. However, she feels equally frustrated at being blocked by the physicians in performing other procedures in her practice, procedures she knows have been well proven to be performed by NPs as good as or better than physicians.

> So whenever there is one patient that would need a PICC line in the ICU, we will be involved in inserting it, plus anywhere else in the hospital, which is quite new here. And so it is nice developing some clinical skills which in the NP role here we've not been allowed to do, you know, inserting art lines, inserting chest tubes; it's really not part of our practice at all. In the unit, the docs, are not open to that yet. ...they say, because we're in a teaching hospital, every resident and fellow that comes in wants to do technical stuff. So we're never, never involved in any of these intubations. Never. It's not even discussed.

Being able to engage in highly skilled functions is a portal of entry to professional advancement and autonomy and to cultural authority and visibility. When ACNPs are obstructed from engaging in the instrumental part of the role that is traditionally aligned with the medical realm and highly valued by our society, it undermines the credibility of the ACNP role as one of independence and authority. This subsequently creates doubt and confusion in the public's mind about the very nature of the role. Patients and their families have difficulty accepting the role and the person in it as valid. As this ACNP poses, perhaps it even calls into question the very trustworthiness of the ACNP.

> Well, you know, you meet with the family, you explain to them that you're doing an important job, that yes you're a nurse but in an expanded role. And you're with them and you develop a relationship and then whenever something happens you've been pushed aside because somebody else is going to take over, so your credibility may be challenged in the face of the family. And this is the way it happens, you know. Because if I say red and it's red, and whenever something happens you're not skilled enough to do it, maybe the color that you expressed before wasn't right, right? Maybe, you know. So we claim we're doing continuity of care, and we make a claim in face of the family that we're as knowledgeable as anybody else on the medical team, and then whenever something happens, you're suddenly not skilled anymore. So we're put in a difficult situation.

Since the emergence of NPs in the 1960s, the discourse has asserted that NPs are differentiated from other nurses, in large part, by having expanded "their use of medical instruments and the use of instruments in ways previously denied nurses" (OTA, 1986). The personal autonomy, authority, and visibility this has afforded has been contentious and viewed unfavorably by many in the nursing profession (Harding, 1980; Purnell, 1998; Sandelowski, 1997, 2000). However, this discourse and the stagnant view of ACNPs as "junior doctors" who relieve physicians of medical procedures they find boring has devalued the possibilities for caring to emerge for the ACNP in each patient encounter. As so aptly noted by Bishop and Scudder (1990), Locsin (1995, 1998), and Ray (1987), when procedures are viewed merely as technique there is a degeneration of what it means to practice. Rather, an encounter between the ACNP and patient holds the possibility for discovering new ways of caring as a result of being in control of the performance of the medical procedure itself. The ACNPs in this study did not deny that they often feel frustrated that a large part of their practice is spent performing medical procedures under time constraints that limit their opportunities to engage in a patient/family encounter that "lets [ACNPs] get to know them on a one-on-one basis" in the way that the philosophical tenets of nursing espouse. Yet despite the challenges that they face in this regard, ACNPs integrate a caring intentionality into their performance that improves the overall well-being of their patients and/or families. Indeed, ACNPs' stories challenge the assertion that ACNPs nurse the technique rather than the patient, as implied by Sandelowski's statement that the NP "role has reprised the one-nurse-to-one-technique, as opposed to one-nurse-to-one-patient, model of nursing care" (2000, p. 189).

In revisiting the illustration of the neonatal NP presented earlier, one can see the possibility for advocacy and taking an ethical stance that is different from that of medicine. The ACNP intervened when the physician was unable to admit that he could not successfully intubate the infant with the TE fistula. She protected the baby from further ineffectual intervention and possible harm by physically intercepting and definitively stating the need for surgical intervention. This illustration and the ones that follow reveal how when the ACNPs' instrumental function is viewed in a deeper way and in the full context of their practice, it is possible to illuminate their nursing identity and the moral imperative they bring to bear on the procedural event itself. Indeed, the ultimate goal of their involvement in performing the clinical procedures is an inherent desire to improve practice on behalf of the common good of their patients and family, that is, to improve their overall well-being. ACNPs recognize and accept that the use of technology is a reality of acute care nursing in Western society. There is no denial that there is a tension created between the ACNP, technology, and the patient. Nor is it denied that some ACNPs may act simply as a technician, proficient, but not authentically present with their patients. But being technologically competent does not have to be polarized with "care" because of its association with "cure." In responding to the patient's call, the ACNP is in fact ethically demanded to be technologically proficient, while accepting the patient fully as a human being, not as an object (Locsin, 2001).

For many ACNPs, advocacy, as it relates to the instrumental nature of their practice, arises out of a fundamental difference in the training of nurses and physicians. In nursing, learning a procedure is "all about the patient," while for medicine, it is "all about the skill." This is clearly demonstrated in medicine's philosophy of "see one, do one, teach one" (Merton et al., 1957), a mantra that causes many ACNPs a great deal of *dis-ease*. But as is so clearly revealed, this has less to do with being scared of doing the technical aspects of the procedure and more to do with wanting to prevent negative outcomes that result from ineptness, and to appropriately manage any adverse events should they occur. In other words, it is about doing what is both right and good for the patient while performing the skill. Consequently, ACNPs ensure that their medical colleagues are present and/or near at hand until they feel ready to accept the responsibility to perform the procedures on their own, even at the expense of being perceived as overly cautious.

> I think they [physicians] were in the mind set of the medical student - see one, do one, and teach one type of thing - which is not my way of doing it. I wanted to be sure that I was doing these things really to the best that I could do...[P]robably the first procedure I had to learn was to remove arterial-venous sheaths... I mean the skill itself is not all that difficult. It's a mechanical skill to do that. The harder piece is the assessment of the patient to be sure that they're ready to have the sheaths out ... So it was a matter of all the assessment piece beforehand. So I mean being confident with the 12 lead ECG's, which I was comfortable with but I hadn't read them in this context. It's different when you're teaching it in the class as opposed to when you're looking at them with a patient who's just had a procedure who you're making a decision based on your assessments that you're going to do something which may or may not change the outcome. So making sure that my comfort level with that was good; making sure that my physical assessment of the patients to make sure they were ready to have the sheaths out. And then managing - in about 15 to 20% of people who have a sheath removal, you can get cardiovascular significant complications right at the time. Patients will have, because of the femoral nerve where it runs, when you're compressing it a lot of patients will have profound vasopressor syncope. Their pressures will fall to nothing. Like, they'll lose consciousness. Some of them will seize,...which isn't great when you're holding an artery and this person's seizing. [laughs]... So you can get somebody with a heart rate of 70 or 80 go to a heart rate around 30 and their blood pressure will go from a 120 to 60 by palpation and they're losing consciousness, and you've got one hand on their groin. And the real problem, I mean that sounds bad enough, but it's even worse if they've had an interventional procedure because the perfusion pressure through the artery, if that drops, then the artery will collapse and then they'll infarct because it's raw area. So it's critical that that perfusion pressure doesn't drop. So learning to manage that, being able to detect it quickly, being able to give the IV atropine, often multiple doses of pressors, tons of fluid and that kind of thing, as well as monitoring them for vascular complications in the leg. Because you're compressing all the blood flow to the leg, you need to be sure that in terms of managing, making sure that you're sensitive to any potential complications that can occur. And each patient is different.

For ACNPs, technological competence as caring is not just about mastery of the skill. Technological competence also concerns being constantly attentive, vigilant, and prepared to respond appropriately, swiftly, and deftly in the event of danger, distress, or deterioration in the physiological functioning of the patient during the procedure. This means that they need to know what to look for. But as stated by Hawley (2005), knowing what to look for is not as simple as it looks.

> Vigilance requires a sound and integrated knowledge base composed of theoretical (scientific) knowledge learned through study (e.g., pathophysiology, clinical manifestations, diagnosis, treatment, and potential complications), practical knowledge gained from experience (e.g., typical clinical trajectories or 'the normal course of events" and known risks or complications in specific patient populations and subpopulations), and particular knowledge of the patient, including the clinical facts (e.g., co-morbidity or co-existing disease and injuries) and knowledge of the patient as person. (p. 181)

This ACNP continues to describe in elaborate detail how each patient can be different by sharing an example of what she termed "an extreme example of the things you can run into." The level of detail provided in her description of learning this skill is an indication of the degree of ethical responsibility she feels toward the patients and the moral imperative she carries to always do what is right and best for them. The realization of human unpredictability negates the view of persons as objects and challenges the ACNP to know the person from moment to moment. The intentionality of the ACNP is to do good (Algase & Whall, 1993) and to be fully present for the patient. It is argued then that technology can only be rendered safe in the ACNPs' hands when they are adequately prepared. Entering the world of the Other is coming to know the Other as a person more fully through the competent use of technology (Locsin, 1998). This cannot occur under the casual and inattentive medical teaching/learning tenet of "see one, do one, teach one."

> I recall one patient who had a very large hematoma that had developed during the [angiogram], so removing the sheath was really difficult because she already had a large hematoma on top of the arterial site. So it's very difficult because you're compressing now through a hematoma. So you've got to inject local anesthetic because it's extremely painful to be compressing that very tender area. And she actually initially was okay and then the next day was up in the bathroom and they called me because she'd gotten up to the bathroom and felt a pop when she was up and went back to bed and her leg was just expanding. So she was bleeding; her femoral artery was bleeding into her leg. So we had to recompress her and again finding the artery through all this humongous expanding hematoma wasn't fun and she was losing a lot of blood. And we managed to get her stabilized, had to cross match her for two units of blood and she had to go for emergency vascular surgery, which is only two in my five years. So that one stands out in my mind because you know you sort of have to be prepared even though the majority will not be that extreme. There's always that potential for occult bleeding; you know, they can bleed into the retro-peritoneum, because I mean the femoral artery can exsanguinate in three minutes. So the technical part of the procedure isn't a huge thing. It's more the being comfortable managing everything else. So when I was learning the procedure I did the usual - watched a few and did quite a few under supervision and [the physicians] were great because they agreed it was whenever I was comfortable. And after awhile they said, "Okay. Well we'll just go and wait at the nursing station and if you need us we're here." So there was a gradual weaning and I was probably ready to do it long before I let them go. But it was just more my feeling that I wanted to be comfortable because when I was doing it on my own, they were in the lab, they were scrubbed in the lab, so if there was a problem they weren't able to come and help me. So I had to be able to manage anything that happened myself.

Being committed as embedded in technological competence as caring is also reflected in the ACNPs' need to know the intimate details of the technical apparatus and its association to the patient. For ACNPs, part of knowing the patient is about the patient in relation to technology. More specifically, the patient once again can only be rendered safe if ACNPs acknowledge the patients' relationship to technology and the impact it can have on their care, both positive and negative. In the following passage, the ACNP shares how she needed to be certain of the reasons why things were being done, the necessity and appropriateness of choices that were being made (and in which she was being asked to participate), and the suitability of care (i.e., the administration of an IV medication) being ordered. This can only happen in the context of knowing this particular patient and family in the moment.

> It's also all the technical stuff, what's the IV access if I need to give something. The other day, there was a bedside nurse who was busy with something else and she said can you take over, and I said yeah, yeah, yeah, I'm sitting here anyway so no problem. So a few minutes after, [physician] came and said we need to give this and this. "Okay, oh wait a minute. Do we have that medication?" So I found it. Okay. Now where should I give it? No idea. I don't know the lines; this is really technical but I didn't know where I should give that without [illegible] any risk. So I said I won't do that. I didn't know that patient; I also didn't know why we needed to give that medication, because I was just coming in and I didn't have the time to know the patient, and I didn't know what was the family's understanding of the situation. Is there anything else that I should know on this particular patient? And I felt really pushed because I didn't get the background that justified that thing. I thought I was able to take over but I was missing information.

Knowing "who" the patient is in relation to "what" is required in the way of technical care is an essential element of *being committed* as ACNPs. In knowing the person's (and/or families') wishes, the wish is communicated to the nurse and in doing so, the person allows the nurse to enter the Other's world (Boykin & Schoenhofer, 2001). In this view, the skill is not rendered mechanistic but is revealed as humanistic, interconnected. From this perspective, care being provided by ACNPs is not based upon the evidence-and-cure process, in which ACNP functions are narrowly described as the diagnosis and treatment of disease and the ordering and implementation of instrumental interventions. Rather their use of technologies becomes an expression of caring and commitment. Heidegger (1959/1977) argued that "everything depends on manipulating technology in the proper manner as means" (p. 6). ACNPs have in fact, brought Other into the right relation to technology.

The ACNPs' capacity to make a humanizing difference in their patients' experiences of technological events is what Hawley (2005) has termed "combating the technological imperative" (p. 130). ACNPs express moral discomfort in those situations in which physicians get "swept away" (Tisdale, 1986, p. 429) by the use of technology in the fight to cure at all costs. At the same time, they also experience discomfort when technology is withdrawn or withheld if little regard has been given to the patient's voice. Either situation represents a "lapse of humanity" (Frank, 1991, p. 27) in the face of technology. But ACNPs view their role as an opportunity to better influence decision-making within the health care team by illuminating the human values that are embedded in each situation. *Being committed* reveals itself in technological competence as caring in situations where the ACNP, in *being connected* with patient and family, creates opportunities for the health care team and the patient/family to mutually come to know each other more fully in the moment, facilitating meaningful practice in the use of technology.

> We have one patient right now who is terminally ill with multiple myeloma, and who has had quite a bit of pain, and who's family and just about everybody thinks he should stop dialysis. But I was pretty sure that the patient didn't think he should stop dialysis then because I asked him about it on more than one occasion. And he has a 90-year-old mother and he doesn't want to die before his mother; he thinks that's too hard. He's a quiet man and you have to sort of pull it out of him, never married and has these siblings who love him and are very good to him. But the family was really struggling with this, so we decided to have a family conference and because they really thought that he should come off dialysis just because he was in pain - well at that point he was in some pain and he just looked so dreadful - and they were willing to bring him home. He's currently in a nursing home and they were willing to bring him home. And I think they saw this meeting as a chance to develop a plan to bring him home for palliative care to a little town outside of here. And I said okay but we have to have the patient here because I'm not certain what he wants. So I started the meeting and I ended up running the meeting with our social worker - our consultant wanted, couldn't come until later because she had other responsibilities - and I started the meeting and I asked the patient what he wanted. And he didn't say anything really because he's this quiet 70-year-old bachelor I mean. So I said, "I'm going to push here because everybody's here because they want to know whether or not you want to continue dialysis, and if you don't, we want to begin to plan to get you home so that you can enjoy some time with your family in your old home. And he was ambivalent; I know he was. I said, "Should we plan?" And he finally said, "Well I guess maybe we should plan." So we planned, but it was a Friday and we knew we weren't actually going to be able to get the plan implemented and talk to [community services] until Monday. And by Monday he had changed his mind. And I actually feel badly about that. I hope we didn't coerce him, but the important thing was that everybody then realized that [patient's name] didn't want to come off dialysis.

By establishing a relation of intersubjectivity, ACNPs are in a key position to speak out on behalf of the patients. Because of their involvement over time, they come to know the meaning that the health care event has in relation to the person as whole. As a result, they develop an ability to sense from the patient's perspective where the boundary between harm and benefit lies (Gadow, 1989). This engaged knowing enables ACNPs "to speak, not with their own voices, but rather, to the extent possible, with the voice of the patient and in so doing truly fulfill their moral responsibility to foster patient autonomy" (Hawley, 2005, p. 133), what Gadow has argued is the hallmark of true advocacy. Similarly, ACNPs reveal their capacity to make a humanizing difference in the experiences of their colleagues caring for those suffering and dying. In taking the time to help others reflect on patient choices, to respond in a manner that reflects an attunement to and genuine concern for the predicament of others who are sharing the patient's live as lived with the choices made (e.g., nurses and family members), ACNPs further demonstrate *being committed* to both the patient and nursing.

> But because he looked so awful, and because it's such a big unit, even if it's in the chart, you have to retell the story over and over and over again, and you have to help the family who are still struggling with the same issue, which is he's literally got skin over bones and the pain has continued to be an issue that we've struggled with. So, just helping everybody be clearer, including other members of the team, staff and other members of the team, that it's time to stop asking this man whether he wants to continue and just get on with his goal which is to continue dialysis and to have pain relief. And so I'm often sharing that, particularly with the staff nurses, because I mean they struggle. You know, they're spending four hours with him and I'm spending fifteen minutes with him twice a week. But I talk with his family about twice a week and I've talked with the social worker and I've talked with the community support people who were continuing to come back and check, you know, I mean – "No. Don't do that any more. I think he knows he can let us know if he doesn't want to carry on." So in terms of education and so on, there is just that making certain the plan of care is clear and everyone is supported in supporting him.

The desire for more control over the instrumental aspects of practice for many ACNPs is not driven by a personal need for external validation as an ACNP. It concerns the acquisition of control of the procedure to better enable nursing to meet both an individual patient need and to more positively impact the broader care-delivery system. *Being committed* is demonstrated in seeking opportunities to provide holistic care in a more timely and effective manner. Much of patients' and nurses' time is spent waiting for physicians' availability to perform a procedure, resulting in unnecessary discomfort, increasing anxiety levels, and delays in discharge. It is common for patients to sometimes wait all day until physicians are finished their surgical cases or clinical appointments for the interpretation of an x-ray, insertion or removal of a chest tube, administration of an intrathecal medication, or endotracheal tube extubation.

In the following illustration, an ACNP working in a cardiology service shares her story of why she felt it was important for her to undertake the performance of arterial-venous sheath removals post angioplasty. As she so emphatically expressed on several occasions throughout the interview, an ACNP's approach to practice should not be about "what the docs need; it's not what the nursing staff need; it's what does the patient need. What are the needs of the patient that are not being met that the ACNP can assist with?" As this ACNP noted, timely removal of the sheath brings greater patient comfort and autonomy and reallocates nursing care to others. "It's how you can best meet the needs of the patient, and if it means you take knowledge and skills from traditionally medical functions, that's okay."

> And the big one when I first started was sheath removal because patients would be ready to have their sheaths out ,and they can't get out of bed with these sheaths in, so they'd be ready in the morning to have the sheath pulled but the physicians didn't pull them until four or five o'clock in the afternoon. So patients were on bed rest all day when they could have been up walking around and be using the bathroom by themselves rather than the bedpan. So it was a huge problem. I mean the work load for the nursing staff was huge because these patients are on bedrest and had to be monitored with these arterial sheaths. And the core thing was they simply didn't have anyone to take the sheaths out. So that was the first thing I said - okay this is the need, a huge need; that's the first thing in terms of skilled focus that I'm going to work on.

The time spent watching "a patient writhing in pain" while the nurse "struggles to get hold of a physician who won't or "can't answer his pager, to get an analgesic," is recognized as a system's issue that is "just plain wrong," particularly when in most cases the nurse "will get a junior resident, who doesn't know the patient, who doesn't really know what to order," and will, through a series of suggestions, tell the physician what to order. *Being committed* means being able to respond to the patients' needs in a timely manner, "without barriers and hoops," in a way that is integrated with "knowing the patient" and "utilizing the knowledge and skill from both nursing and medicine."

Being committed to the patients and their families is also revealed in the tensions that some ACNPs experience in taking on some of the technical aspects of practice that have been traditionally held by physicians. The burden of the instrumental nature of their practice, either in terms of the responsibility carried, or the belief that the goals and ideals of nursing are at odds with the increasing demands directly associated with technology (Locsin, 1998; Ray, 1987) are negatively experienced. However, it is their commitment to the provision of holistic, continuous care that intercedes. This commitment grows ever stronger when they are in relationships that feel strongly connected or when they are acknowledged by the patient and/or family to be a trusted care provider. The following passage is taken from a much longer and complex narrative by an ACNP who was struggling with the question of whether to continue to be an ACNP. She was not particularly interested in taking on more technical procedures as an ACNP but had been able to reconcile herself to being involved in this aspect of clinical practice when she learned that the patients and families appreciated her involvement.

> You know I don't really mind doing [lumbar punctures, bone marrow aspirates] when I look at it from the perspective that the families really appreciate me doing them. Yeah it's a

> medical technical skill, but I mean everybody has that in terms of their job. You know, nurses have got to put in catheters and do all kinds of stuff. I mean there's that piece of our work right, and that's basically how I view the LPs and the bone marrows, because it gives comfort to the families actually to know that I have an expertise in that area, I can do it quite well, and they know me very well and they trust me with their child and this particular painful procedure. So I don't really have a major problem doing that. At first, I wondered, how will this go? I'm not sure I want to do this, that kind of thing. But when I looked at it from continuity of care and that kind of thing I think the families do really appreciate me doing it.

Similarly, another ACNP shared the following when she revealed that she hated inserting chest tubes.

> Well, I guess it's the reason why we're here you know. We're here to help patients and we're here to hopefully get them better and get them back on their feet. And everything you do you do because the patient needs to have it done and I guess the ultimate goal is for patient comfort and good patient outcomes. Isn't that why we're nurses because we're here for the patients? And you know what? I probably could say I really don't want to do that [the procedure] and somebody else would do it eventually, but I mean that's my job and that's why I'm here. I'm here to help people and why would we wait for somebody else to do it if the patient needs to have it done now? I know there are some NPs on the wards, they don't do any technical procedures quite like that because they just don't feel comfortable doing it, but you know what, sometimes that's to the detriment of the patients because then they have to wait for the residents to get out of the OR and stuff like that. And I don't know, I think we're here for giving the patients the best care that we can give them and I think that's part of it.

As many of these passages bring to light, *being committed* as embedded in technological competence as caring is about the ACNPs' desire and capacity to comfort the patients and families for whom they care. *Being committed* to provide comfort is interwoven with becoming and *being comfortable* clinically. The provision of comfort is an ethical dimension that is eagerly embraced by the ACNPs as they gradually become competent and confident. ACNPs demonstrate through their stories that *being comfortable* also means that they are committed to use themselves in relation to instrumentation in such a way that they can physically or emotionally strengthen their patients or families and/or diminish their anxieties or concerns. In short, *being comfortable* is also about *being committed* to providing comfort in order to bring others comfort. The ACNPs' experience *of being comfortable* is augmented when they can provide comfort and is expressed in feelings of satisfaction, gladness, and even joy. More simply stated, they now feel they are able to make a difference in a way they were unable to do in other nursing roles.

> I like kids not to hurt. I work with a good team of anesthesiologists that are very wonderful people that believe in the same thing as me of no pain, which is wonderful, because as you probably know too, that didn't used to be the case. So it's been three years of hard work to get to the point where I am; that they're not scrounging up screaming kids, and hurting them. So that's part of the joy is just that we do now - because they're very painful

> procedures - and I do them with no pain and we take kids down in wagons happy to have a bone marrow done. And they are very, very painful procedures, and they go down and we have a treat box and give them all sorts of things and I have a lady that works with me to get them into the room, and like I said, a team of pediatricians that help me sedate them, and then the technicians that take the specimens. I love to get good specimens and get good slides. I'm a bit of a nerd. I like to get really good slides and if they tell me I've good things I get all excited. I like the guys in the lab to report excellent specimen. [laughs] I like the report to come written that way because then I feel like I've done the best possible job that I could and that the child doesn't have to go back to sleep again for another one. And I've been involved a lot in spinal tap technique and needles and doing the best possible needles to the least headaches that you could ever have in a size of needles and that sort of thing with the department of anesthesia. So just to be able to just do it once, never again, just one shot, and I like to have perfect spinal taps and no bandaids, no anything, just shoot it in, and I'm arrogant as all get out. I like to aim it in and never miss and to get clear fluid with no blood. Yeah it's pure joy to do a perfect procedure.

At first flush, one is struck by the proud and bodacious nature of this description, her ability to identify her own strengths, the confidence she has in her own skill and ability. It reminds me of surgeons' arrogance and certitude and their surgical motto, "Sometimes in error, never in doubt" (Cassell, 1987/1992, p. 175). There is also a sense of self-competitiveness with her performance, a striving to be perfect. But on closer examination there are other layers to be revealed, layers associated *with being committed* to a technological competence of caring. First of all, performing the diagnostic procedure well makes a repeat procedure unnecessary and the findings more reliable. Secondly, being able to do the procedure perfectly also means that her patients will experience less discomfort following the procedure, and adverse effects will be minimized. But one also sees that this ACNP has embraced the performance of the skill from a holistic viewpoint. By embracing the procedure, she embraced the opportunity to change the philosophical approach to the way in which the patients were cared, thus revealing the moral agency of her ACNP practice. Seeing an opportunity to change the way in which the children were sedated for the procedure, the ACNP seized the opportunity to work with neurosurgeons, oncologists, anesthetists, psychologists, and child life workers to initiate a procedural program that took the developmental needs of the children into consideration along with the pain and sedation management issues. A choice of pharmacological approaches, enhanced with hypnosis and play therapy, were part of the program. Inclusiveness of team to better meet the holistic needs (that is, mind-body-spirit) of the patients in creative ways is strongly evident in her stories. Connecting with the children through demonstrations of tenderness and caring during the performance of the skill were also evident in unique ways. *Being committed* as embodied in technological competence as caring is revealed when ACNPs demonstrate compassion, conscience, competence, confidence, and comportment (Roach, 1987).

> I put nail polish on them when they're asleep, you know (pause) - I'm just trying to think of this little boy that's just moved here from [province] - and I don't know how he knew about me before he came. Maybe someone in [province] told him that when he came down to the OR that he was to have a date with me and he would get his nails painted. Well it's anytime during the procedure. It's usually at their last time or sometime during their treatment, but yeah. One of the boys that I cared for runs in the same circle as my daughter. He's about twenty-years old now, but when we treated him I learned how the boys appreciated it because they were bright silver and he went out to party with them silver and he told everyone that her mom had done them in the operating room, so I know they did like them.

The stories shared by ACNPs reflect their capacity to give beyond the practical significance of the act of performing the skill. There is a generosity that is demonstrated in "the skilled touch, a seeking contact with the person as much as it seeks to effect the task" (Frank, 2004, p.6). One final example presented here serves to highlight this same moral agency in the ACNP practice as it is associated with *being committed* as embodied in technological competence as caring. The ACNP in this illustration acknowledged that learning new technical skills appealed to her because she believed that nurses "could do better than the residents" because they are "so busy and so rushed that they don't have the time or the kind of skills that nurses have to insure that all the patients needs are met when they are doing the certain thing", including their pain issues and comfort.

> This is what used to happen every day. The residents would make rounds; they'd come around, they'd yank out everybody's chest tubes, and they'd leave the unit, right. And that would be at six in the morning and the patients might be sleeping, but it didn't matter because they had to get to the OR. And so when I'm there, depending on the patient's circumstances, well before we take chest tubes out, I always ensure that the patient has analgesia. If the patient's really uptight, I might even give them a little sedation. We take our time. We don't pull the chest tubes out and splatter them all over the room and leave them there for somebody else to clean up [laughs] and we try not to get everybody else in the surroundings covered in goo [laughs]. We explain to the patient what we're doing, how they might feel, that even though the tubes are down here, they might feel pain up here, they might feel it in their elbows; you know those kinds of things, and try to sort of give them a realistic expectation, but try and make it as comfortable as possible. We had a patient who had Down's Syndrome and he was in his early twenties perhaps, but he had the intelligence of a much younger child, right. And you know he was very scared at having heart surgery and he needed to have an internal jugular line put in because he was septic. And so I needed to do that for this fellow. And it took forever to do it and we needed a lot of patience, but we have artists on the wards in our hospital, and this fellow came around with his guitar and he sang and played for the patient while he had his head sort of covered with drapes and stuff. And it was such a relaxing, calming, soothing environment that the patient did awesome. We gave him some pain medication, we gave him a little bit of this and that, but you know he tolerated the procedure so well and it was just awesome. You know I would recommend that for anybody and that's not something that you would see the medical people do, and so I think nurses are much better at that kind of stuff.

Being committed, particularly as it relates to their involvement in the instrumental nature of their practice, is also revealed in their willingness to accept and reflect upon their failures and mistakes. The intent of their reflection is to modify their approach in order to provide better care, the best care, they can to their patients during the performance of these procedures. It has been brought to light that *being comfortable* and *confident* means being at ease and experiencing a sense of routineness to their work. This does not mean however they become unconcerned about the responsibility they carry in relation to what they do, nor do they become blasé. The mere fact that ACNPs have stories associated with past mistakes and then chose to recount and reflect upon them during the interviews demonstrates the need they have to express their concerns and anxieties. The retelling is a means of reaffirming that they continue to be caring persons in highly technical environments. These stories are ethical ones and are another means of revealing commitment and existential caring embedded in the ACNPs' clinical practice. In the following passage, a neonatal ACNP shares a story about an event involving a technical procedure that she believes has shaped who she is as an ACNP. It is part of her identity as an ACNP. The story demonstrates moral agency in that it reveals how she is attempting to build a morally responsible practice as an ACNP. It is a difficult story in the telling, even years later.

> When an infant is born and if they're a critically ill infant we can cannulate the vessels in the cord - and so one of the previous team members was on day shift, and couldn't get this line. I was coming on nights and we got quick handover and then she was going to start the lines but she needed to do her charting and get out of there. And so I took over doing the lines and it just wouldn't go; the arteries are very twitchy and you can get into them part way and it's just nothing. It's beyond your control. So I should have stopped when I was at a point where you think - Okay I'll just try one more time, one more time. And then you just sort of have to draw the line. You knew how badly this child needed this line and it was sort of that weighing the balance of do I try one more time or do I not? And just say - this baby can't have a line; it's not going in. Or calling and saying - is there anyone else that could best provide this skill? And unfortunately we had got the two arteries to a state where they were not tryable again by anybody. So you call it off [big breath – heaviness to tone] and then you have that sense of failure and you think - Oh my God I should [another heavy breath]. Anyway as the night progressed, the leg went pulseless and was discolored. Thank goodness the resident who was on in PICU was a cardiology fellow. And we got the Doppler and then he came over ... in fact there was a clot. And so I should not have tried that one more time. Did that make the difference? Did I cause the clot and put this leg at jeopardy because of an obsessiveness to get this intervention done? So living with the consequences of that was tough. I mean the child did fine but it also meant that the infant had to have some anticoagulation therapy, and close monitoring of the limb. And, you know, I was the last person to have tried the line and I probably should have just respected my colleague's call on it, that it just wasn't an accessible artery, and let it go at that, instead of that - Oh well. I'm fresh tonight. I'll give it a try. And, you know, I should have just valued that. So yeah, living with the consequences of that. It's tough to know when to stop, when to recognize your limitations, and then living with a decision that you made that had consequences. And, you know, it's more than just personal self reflection. What have I

> done with it? It's made me a better nurse in terms of respecting when my colleagues say that, I'm not as quick to jump in and say - Oh I can do it better than you, kind of thing, and respecting that they've given it their best shot and unless I'm invited to have a try at it, be respectful of their decisions. Knowing when enough is enough and not being afraid to say, you know, we can't do this anymore to this child. And then thirdly is just to, you know, to be able to follow through and recognize, you know, going to the mom and saying that this was a side effect of an intervention that we were trying to do to your son, was enough to make you, a humbling experience in itself of giving parents bad news on top of other information that, you know, you had a critically ill infant that they weren't planning on. So it, that effects how you give information to parents later on down the road too. So in many, many different venues it influenced my practice.

The ACNP dwells with her story even many years later in the way meant by Heidegger (1971), that is, "to cherish and protect, to preserve and care for" (p. 147). This story implies value (Frank, 1995) and in sharing this story about a mistake she made during a technical procedure, this ACNP calls us back to what is ethically significant. As she identified, it is not enough to only reflect upon the reasons for her failure to have done no harm, but to take the lessons learned and enact them in such a way as to protect and care for others in the best way possible in the future. Her story reveals the vulnerability of patients and their families and the responsibility toward the patient during the performance of a procedure, the need to do things for the right and good reason, and to respect and extend the strengths of our colleagues on behalf of our patients. This is what *being committed* as an ACNP means. ACNPs can and do practice within a one-nurse-to-one-patient model of nursing care despite the extended instrumental nature to their role.

ACNPs respond to the call of the vulnerable who need their care. The vulnerable call them to responsibility; they call upon them to act "responsively and responsibly" (van Manen, 1991, p. 97). Nightingale (1859/1992) wrote that "a careful nurse will keep a constant watch over her sick" (p. 11). But to watch over, or to be vigilant, requires that the caregiver demonstrate a commitment toward knowing the Other. In an attempt "to know" the patient better, ACNPs intentionally acquire a greater depth and breadth of knowledge and skills to have at their command in the actions of caring, not as a substitute for caring, but as an enhancement of caring. Activities such as interpreting data from laboratory and diagnostic tests, observing patient's responses to the manipulation of various therapies, and then engaging in an ongoing interpretive quest (Leder, 1990) at an advanced level, are legitimate ways "to know" the patient who has intentionally called the ACNP to action.

Attentiveness to "details," both knowing them and sharing them; "being familiar" with the routines; the continuous scrutiny of the broad spectrum of technology for pieces of information that assists them "to know" the patients better; are all ways and means that ACNPs demonstrate their commitment to being vigilant. Being vigilant through "knowing" alerts ACNPs to the dangers that those in their charge actually or potentially face. Being attentive to details is one way they can help to keep each patient safe from harm, to help each patient remain whole and complete in the moment.

> One day a Fellow commented to me, "Oh that's funny." And I said, "What do you mean that's funny?" And I was doing fluid orders, so I went to the patient, looked at the pumps, looked at the different IV accesses, and I was doing my things. And she said, "That's funny because the resident would sit at the desk and would try to do his best but without ever looking at the patient." I said, "Come on, it's IVs, medications are going to the patient, I need to look at them." And she said, "Yeah, yeah, yeah but he would look at the chart, and maybe ask the nurse, but he wouldn't look at the patient." I said, "Yeah maybe that's a good difference. We'll look at the patient, we deal with families, and we sit with them, we spend time, which may be different than what the doctor will do." [laughs] Yeah, that was funny. Just fluid orders, it's nothing, but you know the patient is getting the fluids.

> We're in the ICU; some of our patients are not doing well, and sometimes we can go too far in terms of treatment, so if I don't know the perspective of the family, then maybe the team will not get to the right decision. And I think it's part of my role to know the family's perspective in terms of where we should be going in terms of treatments.

> As the NP I need to be the one who needs to ask the questions that nobody really wants to ask. If we're to help, I need to know about how this is impacting on them as a wife and a mother. Financially, how they're doing financially. You know, some families will say, "Well fine." And as a nurse I'll say, "Well what does fine mean?" because then I can get a sense of do I need to look at other resources to help them, because some families don't know that there are resources out there, especially depending on what the disease is in terms of even respite and all of that. And like, death, dying, coping, the marital relationship, siblings yeah, all that kind of stuff, I'll ask because we need to know.

There has been an assumption that by knowing the patient biologically in a deeper and broader way, the ACNPs' focus of care will be reductionistic and objectified, resulting in the traditional series of problem-solving actions (i.e., embedded in a medical model of care). Yet, in these passages, ACNPs demonstrate that "to know" the patient in the moment does not equate to understanding the patient as persons needing to be fixed according to predicted conditions. To "know" the patient's physiological status in the moment, or to "know" which life-saving or life-enhancing treatment options to offer, taken from a focus of commitment, is to be interconnected with the patient. The ACNP is then challenged to respond authentically and intentionally as an advocate for the patient in the moment and in the particular. This requires that the ANCP "know" each patient fully as person. Such is the case in the following illustration.

Mrs. Jones was a woman living with an inoperable neuro-endocrine tumor. Her husband had brought her to the oncology clinic because he had found her generally unwell, with intermittent temperatures and confusion. Concerned that her cancer had metastasized to the brain, Mrs. Jones was admitted to the medical oncology unit for follow-up tests under the care of the ACNP.

> So the very afternoon she came in, I reviewed the orders they had written in the clinic, and they forgot about half of her meds, so I had to do that. Then I went to see her, and the nurse came to me and said, "By the way, her temp's 39.4." And this lady is usually very talkative, very vivacious. She's 73, you'd never know it. She's involved in all kinds of women's things, the women's institute, and she's hardly ever home when you call her. But she was not well. She was curled up in the bed, very withdrawn and didn't want to talk and you could tell she just didn't feel well. Anyway I said, "Well you know they're saying that a lot of what you're experiencing could be drug related" - she's in a clinical study because she's progressed on every other therapy they've given her, so she's in this trial and some of this could be related to the study drug itself – "However let's do blood cultures."

Although the "last thing anyone had expected" was that Mrs. Jones would have an infection because "her white count was normal," the ACNP was able to call upon all of what she "knew" about Mrs. Jones to make the decision to test for other possible reasons for her behaviors. In so doing she avoided closure. She did not abandon the search for the cause to Mrs. Jones' symptoms in favor of the "logical and predetermined" rationale. Being attentive to *all* the details of the situation, including scientific, instrumental knowledge, she was able to discover that Mrs. Jones was septic. Knowing this particular patient in a qualitatively distinct way combined with what she knew to be the normal presentation of patients with sepsis, enabled her to intuit a problem that was incongruent with what one would typically expect. She immediately initiated the appropriate lifesaving medical treatment of intravenous antibiotics. Within several days, Mrs. Jones was "feeling better" and the ACNP began to initiate discharge planning. The ACNP's vigilance helped to keep Mrs. Jones safe from harm.

In addition, the ACNP observed during this admission that Mrs. Jones' husband "was quite nervous about taking her home." He had expressed concern that "nobody was paying attention and nobody was doing the right things" for his wife prior to her hospitalization. Acknowledging that a lot of what she did as an ACNP was "to get people to a point where they feel safe to go home," the ACNP felt charged with a duty to reduce the feelings of anxiety that arose from the burden of care that Mr. Jones was experiencing. First, she ensured that home visits of physiotherapy, occupational therapy, and nursing care were organized upon discharge. Then the ACNP worked with the patient and husband in such a way that she could assist them both to cope with the emotional crisis they were experiencing.

> They feel very safe here and very cared for and almost cocooned, so when it comes time to kind of launch them back home again it, it takes some planning. And anyway, what we were prepared to do was to LOA to discharge, which we don't do very often, but if we're in this situation where somebody's nervous – "Well what if the fever comes back or what if

> this isn't the right medication?" I said, "Okay, well what we can do is we can give you a leave of absence tonight and you just call in tomorrow and if the night went well and there are no problems, then you just call the nurse's desk and say I'm staying home and then you'll be officially discharged." Well I thought that's what we were going have to do, and in fact the husband wanted to leave it until Saturday. "Let's do this Saturday to Sunday rather than Friday to Saturday," and I said, "Well let's see how it is tomorrow morning," and the wife said the same thing. It's just that she wants to get home now that she's well again. And so I went in this morning kind of prepared to say, "Okay we can be flexible. It'll be either today with discharge tomorrow or Saturday to Sunday," and he said, "No I think it's fine. I can see that she's a lot better and she's getting better by the day and why take up a bed when I'm sure you have other people who need this bed and with health care dollars being what they are."

As revealed in their experiences and stories, ACNPs act "responsively and responsibly" by knowing the patient and their families holistically and in relation to one another, understanding that each may not have the same needs in the moment. Being present to hear their concerns, including those that are spiritual and psychosocial, and then responding to them in a way that is inclusive and egalitarian is about *being committed* as ACNPs. *Being committed* is about "doing a lot of teaching and a lot of listening and as much as possible letting them have the control and letting them make decisions that are appropriate for them to make." It is about knowing the system and then using it in such a way as to offer patients and their families creative solutions and options that help reduce the chaos that each may experience during the illness event. They do not seek closure to the relationship simply because the physical problem has been solved. For ACNPs, *being committed* concerns "taking responsibility for all the issues," be they "treatment-related side effects," or the "psychosocial and spiritual issues," "right from the onset of diagnosis, through the course of their whole therapy," no matter "how huge a job" it is. *Being committed* is about ensuring their patients and families "don't fall through the cracks." *Being committed* is about taking ownership for "being with" and "being there for" their patients, in the moment and from moment to moment, through consistency and continuity across time and space. "To know" requires that ACNPs are committed to *being connected*.

Being Connected

As is the nature of acute care in today's health care system, ACNPs describe many of their relationships with patients as intense and of a short duration. Despite this reality, ACNPs are clear that *being an ACNP* is all about their commitment to the development of a relationship with their patients and/or their families; it is about *being connected*.

> The best part of the day is actually just sitting down with that mom or dad and just hearing their stories and trying to understand this crisis that they're in from their perspective. ... For

> many of our families, it's the first time that they've ever had to deal with a crisis of this magnitude, so, outside of all the other resources - the social worker and our CNS - as a nurse practitioner, what else can I do for this family to try and put all the pieces together and keep it together and identify what their needs are? That's the best part of the day. I may not be able to solve any of the problems but it's the listening and trying to understand from their perspective, listening to their stories.

ACNPs often struggle to find the time for that connection on a daily basis. They struggle with creating the opportunities to make connected relationships that they find satisfying and sustaining. The rapid turnover of patients in the unit/service, their responsibilities to provide the clinical management for all the patients, along with the families' preference to seek information directly from the physician, can interfere with their ability to get to know the patients and their families in a way that allows them to feel connected in deep and meaningful ways. One critical care ACNP expressed this struggle to develop more connected relationships with patients and families in the following way:

> So when I was a bedside nurse I found that the relationship with the family was significantly better because you're there all the time and you're comforting the patient and they're seeing your interactions with the patient. You just get to know them better. As an NP when you come along and you talk to the families, it's more an information-giving session, a question-answering session; it's not as much of a sort of one-on-one, get to know you kind of thing, unless the patient's there for a significantly long time and then you get to develop that relationship over time. It's just because you don't have enough time at each patient's bedside. Sometimes I struggle with that whole thing because if the patient's family is wanting information, they're often wanting it from the doctor, or they're wanting it from the surgeon, and they're not happy talking to you because you're not him, right. And a lot of families don't even know what an NP is, for starters. So you have to try to develop that relationship and say this is who you are and this is what I do and I'm always around and if you have any questions or you want to talk about what's going on with your family member and stuff we're here for you. And I like to get to know them on a one-on-one basis, but it's not always possible, and that part I really, really still feel a significant need to try to improve. And it's that whole thing about where you fit in because you're not with the patient all the time and you're not the doctor, so what are you really, right?

Yet despite their struggles, ACNPs experience profound moments of connectedness that occur through showing respect and sensitivity to the needs of the patient and family; talking to, listening to, and being honest with them; being available to them by encouraging them to call if problems arise; and appreciating them as human beings. "And I always give them my business card and I say, 'you know, in the meantime if anything happens, if you have any questions, or you start feeling unwell again, I'm on my pager. You just call me." One ACNP told of using spare moments in her week to "call up four or five of [her patients] just to say, "Hey, how you doing? Nothing's wrong. No you don't need to come in," simply because "they really appreciate that." Another shared that the most personally satisfying time in the day was when she was able to create even a few moments with a patient to "just sit there and chat about their garden." The

ACNPs work hard to purposely create caring occasions, caring moments, in order to build connected relationships. Even such a simple but respectful and generous act as the use of spatial arrangements opens the opportunity of *being connected* with their patients.

> You know, the cardiologist stands, the NP sits down. I say, "Well come into the quiet room, let's do this, let's do that or come sit here and we'll talk about this," and that's very different than what they're use to. They're use to a cardiologist coming in and standing over top of the echo bed and standing there while they're sitting. They get to ask a few questions, he makes an answer and then he says, "Okay I need to see you in such and such a time and then he goes away.
>
> [P]ersonifying care, that's probably one of the biggest things. You know the patient is not the heart in bed six or that's the liver in this bed or that's the transplant. You know, that takes away from the personal aspect of that patient. So using first names, that's really, really important. I actually got a letter from a mother last summer... and the one thing she said is that each and every day, I called her baby by her first name. I didn't say Baby Brown, I didn't say baby whatever; I said her first name, always, whenever I saw the mom, whenever I saw the dad, whenever.

In other words, ACNPs believe that the patients and their families want to be heard and attended to. They embody the belief that "an important component of healing, apart from the effect of any technology applied, derives from the relationship between the healer and the patient" (Matthews, Suchman, & Branch, 1993, p. 973). These illustrations reveal that *being connected* with Other begins in the welcome and the opening of self to other. *Being connected* is a form of generosity and as Frank (2004) has noted, "generosity begins in *welcome*" (p. 2). The welcome is a "hospitality that offers whatever the host has that would meet the need of the guest" (p. 2).

ACNPs hold a profound respect for the value of connectedness and the comfort it provides. *Being connected* is one person's promise not to abandon another. In the following illustration, we witness the struggle it is for ACNPs to sustain their moral commitment to their patients and their families when they are continuously challenged to battle the physicians' commitment to medical education, fraternity, and an orientation of disease. The ACNP tells of the time that she arrived for medical rounds only to be informed by the staff physician that she would not be needed in the clinical area because of a surplus of residents scheduled for the month. Although her initial reaction was one of shock and disbelief, she immediately connected with the patients and families for whom she had been caring to explain the situation. She was concerned that they would feel abandoned by her or believe she had not valued their relationship. But in attempting to smooth the transfer of the patient's care from herself to a new medical care provider, she recognized that the change was going to cause unnecessary suffering. She was reminded that connectedness matters. Our patients and families need it in times of vulnerability; ACNPs desire it as part of their moral commitment; human relationships are important to well-being.

> And I went to the family and said, 'As a team we're thinking about maybe giving your care to a good resident, a paeds resident that would be really good with your son, really good with you; and it's not just anybody, it's this particular resident that will continue what we've been doing with you.' And it might have been my mistake to accept the staff physician's decision, but she started to cry and said, 'No, you cannot leave that way and leave me alone with all my problems, and it's not going well, and at least one thing is that we've got continuity and we've been really happy to see you on a daily basis. No you cannot leave that like that; and you pretend you would come back and nothing would happen.' I said, 'Okay fine, fine, I'm sorry about that. I'm sorry that I even told you about our thinking.' And she said, 'Okay thank you, thank you.'

In response to this situation's question, "What am I to do?" – what Frank (2004) describes as a microethical moment - the ACNP subsequently chose to follow through with her commitment to the patient and family by successfully defending her need and right to remain a part of the clinical management of those patients and families with whom she had been previously involved. This story is not about the ACNP arguing that she provides better care than the physicians. It is not about her fight for a de-marginalized position in clinical management because she had, at least for the time being, been blatantly declared superfluous. Rather, the mother's reaction to being "handed over" crystallized for her the essential moral commitment she carries as an ACNP. "Holding to the difficult" (Frank) in the interpersonal, locally contextualized, moment-to-moment, she chose to fight for the right to remain connected because she understood its therapeutic value.

Being connected describes how the ACNPs' effectiveness is based on relationship-centered caring with the patient, their families, and sometimes even the community (Watson, 2005). For many ACNPs, their patient/family relationships involve much more than treatment of disease. Their stories reveal the development of partnerships with their patients and families regarding health and illness management. *Being connected* means that ACNPs establish a relationship with patients and family members that respects their values, knowledge, and skills. They grant the voices of the patients and their families as much authority as their own. *Being connected* in this way is the difference between speaking *about* and speaking *with*. This respect invites patients to be open and honest about their health concerns and struggles. This, in turn, provides a fuller picture of the patients' situations and allows ACNPs to make accurate diagnoses and to fashion an individualized management plan. By collecting data about varying aspects of the patient's life, the ACNP is able to understand health and illness concerns from a wider perspective than that of a list of medical diagnoses. This understanding allows ACNPs to be more effective in meeting the true concerns of the patient. This is illustrated in a passage previously explored in relation to *being confident* but, as was alluded to then, there is connection to the ACNP's moral agency.

> Whereas I like to know more about the people and I guess maybe more of the social aspects than actual medical base. But I think it's important too because I think it all plays in. I mean often times when we have patients, the very sickest ones that have to have continuous intravenous infusion of Flolan, which is a pulmonary vasodilator, all they can do is walk around with this little cassette with this infusing constantly. And quite often a couple of them will come in with headaches and you know something's wrong with my Flolan or the pump. Well no, they've had a fight with their son. So it's the other things in their lives that are going on that if you just sit there and talk to them things are okay and you don't need to change anything medically because there's really nothing medically wrong. So I think it's just as valid as dealing with their medical condition.

This example, and several others that will be offered, illustrate that by encouraging the patients and their families to talk about the biographical and social contexts of their lives, ACNPs empower their patients by maximizing their voices. As an outcome, the asymmetry so common in the medical relationship is minimized. Fisher (1995) wrote that "it is this combination of medical and psychosocial skills that differentiates nursing from medical practice and that grounds nurse practitioners' claim for professional autonomy" (p. 9). Many ACNPs understand that each patient is balancing a unique set of commitments and obligations, such as work and child care, which determine the amount of energy that they can bring to caring for self or their loved ones. Each person has a personal history of successes, failures, hopes, dreams, and fears that shape how he or she responds to the event of illness that brought them into the ACNPs' care. They realize that each patient also presents with varying cognitive and reasoning skills that they use in self-management of their condition. They recognize and respect that each patient and family has unique values, beliefs, and goals as to how they choose to live their lives. Patients bring a unique set of strengths and weaknesses to the health situation. ACNPs know how important it is to understand these strengths and weaknesses, values and beliefs, fears and goals, when negotiating a treatment plan that will optimize health.

Several examples are provided here to demonstrate these aspects of ACNP clinical practice. The first narrative has been shared by an ACNP who works with patients with an HIV diagnosis. In this participant's telling of the story of a patient whose cultural and religious beliefs prevent him from taking his medications, the ACNP shares what *being connected* means for her in her practice.

> There's one individual that we have who's had HIV for quite a number of years and he's Muslim. So he was never really that interested in taking his antiretrovirals. He used to come in and we would figure out from the lab tests that he hasn't been taking his meds even though he says he was. And he says, "Oh yeah, I take them every day," but the lab test didn't support that. And I don't know, for some reason we developed a bond. I don't know how we did, but we did. And so I think I spent about two hours with him one day and we talked a lot about religion and spirituality. And I'm Jewish and so he was interested in kind of where I was coming from and I was interested from about where he was coming from. And through just talking a lot, he said basically that even though we were trying to do our best for him, his basic belief was that God was going to decide what was going to happen to him, and it wasn't us that was going to decide that, it was Allah. And so we talked a lot about that. And once we kind of got to that point where it was out in the open, the pressure was off to try to improve this individual's compliance or adherence or whatever word you want to use. So every time I see him, we always talk a little bit about spirituality, religion kind of stuff and he asks me to pray for him. But he's not taking his medication and he still believes that Allah's going to decide what happens. And we talk about things like not being able to talk to anybody about his infection because it's not something you discuss openly in a Muslim community here. And the fact that there was a lot of pressure being placed on him to get married, but he knew that he couldn't get married because he had an infection, and he wouldn't be able to disclose this to a potential partner. And the expectation is that they would have children and he said he ethically and morally couldn't put his potential wife at any risk of infection. So we had long discussions about this and I don't think that if he'd been seen by a physician that that would have come out. .... And so I don't know, I think we have a bond, some kind of bond there. And so I don't pressure him about his medications and we just kind of understand where we're each coming from, but there's no pressure.

This story reveals the emergence of what Mishler (1984) referred to as the voice of the patient's lifeworld, which is different from the voice of medicine that Mishler acknowledged was overwhelmingly characteristic of the medical worldview. In an attempt to provide care, this ACNP nursed both the physical and the emotional/spiritual wounds of this patient. Through the creation of "a bond" with the patient, she attempts to diminish the asymmetry in the provider-patient relationship and maximize the patient's input into the encounter. Leder (1990) has written that being connected – "a bond" – is created whereby one can sympathetically enter into and understand the experience of the other. "The ultimate grounding of all understanding…depends on a pre-existing bond between all individuals" (Gadamer, 1960/1989, p. 189). There is no sense of blame or judgment evident in this story or need to coerce the patient to become "compliant" with his medications. She does not medicalize the patient. In doing so, she avoids closure both at the time and over time. Instead, she makes herself available and accessible by sharing a piece of herself. She lets the patient get to know her too and in doing so the ACNP legitimizes the patient's feelings about his life and his illness.

Moreover, the ACNP contributes to a renegotiation of their identities, for as Charles Taylor (1994) argues, "my own identity crucially depends on my dialogical relations with others" (p. 34). While they remain provider and patient, they also relate to each other as people. By sharing her own cultural and religious beliefs, this ACNP identifies herself as both similar and different from her patient. As a result, she legitimizes her patient's experiences, while at the same time is opening up the opportunity for reflecting on the differences in new ways. The ACNP knows her patient as someone whom she affects, and she knows herself as affected by the patient, who has become part of who she is as an ACNP. In doing so, the ACNP resists dominant cultural assumptions. It is what Mikhail Bakhtin, as quoted by Frank (2004), calls deepest communion: "to be means to be for another, and through the other" (p. 20). This communion permits us to grasp what makes this moment moral. In *being connected* through dialogue, the ACNP renders both of them heard, recognized, and remembered. This is the premise underlying Gadow's (1980) proposal that to regard "the patient as a 'whole' would seem to require nothing less than the nurse acting as a whole person. Therefore, the person who withdraws parts of the self is unlikely to allow the patient to emerge as a whole, or to comprehend that wholeness if it does emerge" (p. 87). In other words, in *being connected*, by being open, receptive, and available, the ACNP was present to the Other.

> The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resources. For the one I am a presence; for the other I am an object. (Marcel, 1948, p. 26)

Connecting with patients by opening oneself also demonstrates that the ACNP/patient relationship is not built on the foundation of the patient's own incompetence. The patient is treated as the expert on his own life and as such is free to choose his own course. "Committing yourself to dialogue with people is more than recognizing their inherent dignity and defending their rights; it's being willing to allow their voice to count as much as yours" (Frank, 2004, p. 44). *Being connected* in this way is one of the ways ACNPs are able to make a difference.

In this situation, the ACNP did not independently define what was medically relevant, nor simply confine medical relevancy to the patient's medical symptoms; rather she repeatedly made attempts to create a genuine opportunity for connectedness by generously offering herself in terms of time, space, and person. The ACNP left the way open for psychosocial issues to structure the exchange and to be part of the meaning of the illness event itself. This is revealed in a subsequent story she shared.

> One of my clients has schizophrenia. I mean from an HIV point of view he's doing very well. He always takes his medication. He comes into the clinic to see us on a regular basis but he also comes in on a regular basis to see a psychiatrist who happens to be downstairs, so after he sees his psychiatrist he always comes up to see me. And so what he wants to talk about is his son and how well his son is doing and how smart his son is and what his son has accomplished and the relationship that they have with each other. And so we spend a lot of time talking about that. And he had some problems with anorexia which is usually related to his stress levels. He stops eating; he just loses his appetite. So we've had some problems when he's dropped a lot of weight. So we kind of work together to work through some of that stuff. Like he would come in and see me and I'd say, "You know (patient's name), why don't you come back and see me next week and we'll see what your weight's like." Or we work around food, like, "What interests you when you want to eat? What makes you hungry? Or what can you eat? And do you think you could eat maybe six times a day instead of worrying about three meals a day?" and that kind of stuff. But you know, the most important thing for his visit is to talk about his son who lives with his wife - well he's living alone now, but he was living with his ex- wife and she raised his son. So I mean that can be an hour.

Drawing from the family therapy work of nurses Wright, Watson, and Bell (1996), the goal of *being connected* for ACNPs is to enable their patients to discover how they want to live and to find the resources to live this way. They do not regard diagnostic labeling of the individual as a useful vocabulary with which to work.

It is not uncommon for communication among multiple consulting physicians, various team members, and family members, in addition to the patient, to increase the complexity of decision-making. This can be particularly difficult for ACNPs who are involved in developing and implementing the medical treatment plan of care, but who still do not hold the "ultimate" authority. However, as is demonstrated in the following passage, for ACNPs, the decision-making process involves *being connected*. The ACNP in this narrative lived *being connected* with parents who were faced with an end-of-life decision concerning their daughter.

> There's one family in particular that their daughter was quite unwell and it was the results of the ultrasound of the kidneys basically that I was giving to this mom and dad. And it was not the results they wanted to hear; but the kidneys just weren't working anymore. And the question being was transplant an option. And they said, "Fine. So what would you do? If it was your baby, what would you do?" And it was such a hard question for me. Giving the information was hard because they didn't want to know this result because they'd worked hard on trying to keep her alive and had so much hope [her voice choked]. But that was very hard. And everybody else was just, okay this is it; this is great, they could stop. You know, "No, transplant's not an option, can't even think about it." But when they sat and asked me what would you do if it was yours, if it was your kid, it was like, wow you know; if it was my kid, honestly, I said, "I don't know. I guess I'd have to just think how much they were suffering. If there was any hope that it would work, they could still be alive and have a life or the life they still had, I would be doing it. So it's just two ways of looking at it," I said. But. [pause] Oh dear. It was a very emotional situation. They were very sad. We were all crying. It was just a sad situation. But, they understood. They understood where I was coming from. They appreciated that, because they were getting so much of "just stop now." But it was very clear for me that this family couldn't live with the guilt of not having given her

> every single option or opportunity and in this mom's mind she had to look at every opportunity or option, and as a mom I could see the same thing, I'd be the same way.

In this circumstance, the ACNP does not reproduce the hegemonic medical understanding of the case. She supports the parents and, in doing so, speaks an oppositional discourse. Rather than say as little as possible and retreat into silence (as we often witness with our physician colleagues), she opens herself to the parents. She reveals herself as human by openly expressing her emotions, acknowledging the parents' suffering by sharing it with them, "demonstrating that she too is human (as in 'fallible')" which fundamentally changes any perceived power imbalance between them (Hawley, 2005, p. 119). Moreover, by not shying away from the mother's question, - "If it was your baby, what would you do?" (a microethical moment in her practice) – and "holding to the difficult," she lets the mother know that she understands her dilemma and the guilt that mothers/parents can experience. The ACNP calls on her own position as a woman and a mother/parent to be as empathetic as she can. Even while they remain provider and "patient" (an extension of the infant), they relate to each other as women and as parents. The sharing of tears was not a crossing of professional boundaries but rather an openness of self that is *being connected* and attuned with others. The ACNP is *in* the situation with the parents and as such shares their burden for that moment in time.

Similar to the ACNP in the earlier example, by positioning herself in a community of parents, the ACNP identifies herself as like the mother/parents. On this basis of solidarity she legitimizes their experiences, their values and beliefs, their feelings and their choice(s). She acknowledges she recognizes them. These dialogues are examples of what Frank (2004) has described as a practice of generosity, where forming relationships of connectedness help to diminish feelings of isolation both for the patient/family and even the care provider. ACNPs, as demonstrated in these various examples, are able to witness the patients'/families' attempts to understand themselves as morally responsible persons. Likewise, in being a witness connected with others, ACNPs are able to recognize themselves as morally responsible, and they feel connected too.

The following passage from one interview demonstrates that this does not mean that ACNPs do not struggle with the choices that patients or their families make, particularly those that are self-destructive. They may repeatedly offer the same "medical" recommendations and even show their frustration. However, in *being connected* with their patients, many ACNPs reveal that they attempt to avoid closure by neither imposing their medical expertise nor their impression of the definition of the situation. They work to keep the relationship open so that through time, new meanings about what it is like to live with their illnesses may be discovered. By remaining in a dialogical discourse, the ACNP keeps open the possibility that the patient, and even the ACNP, "could interrupt the monological pursuit of their own purposes and self-perceptions" (Frank, 2004, p. 45).

> I can get extremely frustrated with a client but at the same time I still think about where they're coming from, and maybe where they're coming from isn't necessarily where I'm coming from but it's where they're coming from. So that's the reality of it. ... But I'll tell you when one exceptionally good day was for me. It just happened this week. A patient that I have been working with for a number of years - he phoned me and he said - he has a substance abuse problem - he phoned me and he said, "I won't be in for my appointment tomorrow because I've checked myself into [drug recovery program]. So after five years of kind of, you know, planting the seed, you know picking him up, picking up the pieces, having him come into the clinic drunk, and, just being there all the time, and never really judging him in any way, the fact that he called me and said, "I won't be there because I'm checking myself into [the program] and could you please call the psychologist for me and tell her that I won't be at my Thursday appointment either." And I just said to him, "[Name] that's wonderful, that's fantastic," and I said, "When you're finished, you have to come and see me and tell me all about it." But that's a really good day; that's a really good day.

These illustrations of the way in which ACNPs embody their practice demonstrate the ACNPs' desire to create a relationship of mutuality with their patients and families. They strive to engage in relationships with their patients and/or families in a way that is collaborative, reciprocal, negotiated, and participatory. This ACNP, as well as others, do not *tell* their patients how they should deal with the problems in their life. Instead, through *being connected* and *being committed* to "knowing their patients," they put forward some things for them to consider. They explain the importance of health related interventions and treatment options; they teach their patients how to care for themselves; they make recommendations; they circle the issues in multiple ways, revisiting them from a variety of angles. They seek to guide their patients through their encounter with the illness event, helping them to find the path that best fits with their personal goals and aspirations for living. However, they do so in ways that minimize the distance between themselves and their patients, such that even when the ACNPs' treatment recommendations are not chosen, the connectedness is maintained and the possibilities for further negotiation for care remain open.

> And I'm currently caring for a lady who's been getting radiation who developed this really severe pain in her upper back [during radiation].... and I told her to use the breakthrough [narcotic] as she needed it and take her - oh she's got a cough, a really bad cough because it's a big lung tumor which was keeping her awake as well - and we bumped up the cough medicine. And this is a lady who's very reluctant to take any medication and so you prescribe the appropriate medication therapy and as soon as the symptom gets controlled she says oh well that's better, backs off, and won't take it anymore, and then the symptom, like the cough, comes back again. So I've been working with her to try and teach her that

> the reason that the cough got better is probably partly the radiation and I'm sure the chemo that you had three weeks ago has done some good but you know I think the cough medicine was probably helping a lot when we were giving it every four hours. … And if her cough and her pain are very bad then the coping is not so good and she's very weepy. .. But she doesn't like feeling sleepy, she doesn't like feeling kind of spacey, and if you're a person who's not used to taking narcotics, yeah until you adjust to it you feel that way. So a lot of teaching goes on there. But I said, "Well you know you don't have to take anything." And I said, "However I do think if you take the injection of the pain management drug we've ordered before you go for your radiation treatment you'll probably get through it better, because, you know what I'm not sure is if it's just lying on that hard table that's making your back sore possibly, and the physician who's treating you, Doctor [name], said that could be it." He couldn't think of any other reason why her back would suddenly flare up. Anyway I said, "When you get back we'll see. If it's flared up from this treatment then I think we may have our answer and then the trick is to take something pretty strong before you go over." And I said, "but you time when you take your pain medication, you time when you take the cough medication, but I might suggest that if it makes you feel dozy during the day then take the bigger dose of cough medicine at bedtime, because you know you don't care if your dozy at night; you're sleeping right." And she said, "Yeah that makes sense to me so." Anyway we're working on that.

Even within the constraints of a busy practice, ACNPs struggle to give the time and personal attention that helps patients to feel that they are being heard and not rushed. Spending time "getting to know" the patients and families helps both patient/family and ACNPs feel valued. It becomes evident that connectedness as part of caring is as an essential ingredient to curing in the ACNPs practice. As Mishler (1984), Fisher (1995), and others have argued, physicians all too often dismiss the social/biographical contexts of patients' lives as not the "real stuff" of medicine. By treating the medical and the social as dualities and treating organic pathology as medical, physicians leave the way open for two separate but interrelated phenomena. But what has been revealed here is that many ACNPs are driven by the ideology to unify the two in their work.

However, it is not to be taken-for-granted that all ACNPs are able to connect with their patients in the way that has been revealed thus far; nor, is it to be assumed that ACNPs develop these types of relationships with all of their patients, all of the time. As one ACNP realistically noted, "not all patients need or want a close relationship" with their care provider. In the passage below, a contrasting example of how it is that ACNPs can engage with their patients is provided. Instead of being connected with her patient in way that helps to unify the psychosocial and biographical context of his life with the medical diagnoses, the ACNP separates them. As a consequence, there is an underlying sense that the ACNP blames the patient for his inability to "comply" with the medical plan. If he could only control his fears, the proper care could be provided. In other words, the patient's inability to take the required diagnostic tests is somehow at odds with the ACNP's expectations. Because of this, she not only presents the medical system as having definitive authority, but she has also prevented any opportunities for the patient to discover new possibilities for healing. Here the imperative of the ACNP's own agenda is revealed. It is an example of when the ACNP feel his/her needs and purposes are reality; one voice believing that it alone is sufficient (Frank, 2004).

> There's a patient that comes into Emerg all the time and he has known cardiac disease; he had an angioplasty three years ago. And he comes in with chest pain and he also has asthma and he's never sure if it's his asthma or if it's his angina. This person was around Chernobyl during the explosion, so he has a fear, phobia really, of radiation. So he doesn't want any test that involves radiation. Well all our tests involve radiation except for the plain stress test. So he comes in, he gets enrolled in the chest pain program every time, and every time we go through the same thing. Well, I'm basically fed up with him by this point because I think I just saw him last week, this is maybe my tenth time, and every time we go in this big circle. We spent all this time with him trying to explain. So I mean I feel for this man, but I mean I've just been around it so many times. And it's to the point where I've booked him for so many tests that he didn't show up for that no one wants to book a test for him anymore. But oh no, we had to do it again and try to convince him - because his phobia isn't realistic; I mean he gets more radiation probably being out in the sun or going on an airplane or it's a very minor amount of radiation for a nuclear stress test – and he doesn't really listen to what I say. In this case I have totally had it, and given up with that patient.

One of the outcomes of being engaged in the traditional medical model of practice and the social/political discourse that is embedded in this instrumental way of being is that there is an expectation that patients somehow owe something to the care provider. In other words, there is a sense of obligation that is expected because of the asymmetry in the expert/non-expert relationship. This obligation is expected to come in the form of passivity, compliance or adherence to the medical plan, and even expressions of gratitude for having been "saved." This is demonstrated in the following illustration. The ACNP describes how she had "picked up" a myocardial infarction (MI) just prior to a patient's release from hospital. The patient was diagnosed as having had a silent MI which resulted in triple coronary artery bypass surgery before he was finally discharged.

> So yeah he was kind of our text book case, right, the big pick up. And then as it turned out he was called to see if he would participate in our study and he said no, no thank you. Okay, after all we did for you, we saved your life. No. You know, we could have just kept walking on by him and thought he'll be okay. And I remember too there were no beds when we tried to get him admitted, and Emerg was really busy, and I didn't want to take him back to Emerg because they'd get all hot and bothered about that. So I ended up hanging out with him for two hours that day until a bed came available, because - often you'll tell people, "Go, come back to Admitting in two hours" - I was really quite worried about him. So here I'd spent two hours out of my day babysitting him basically because I was afraid to let him out of my sight and he still didn't think that was such a good idea to participate in the study [laughs].

Sharing this passage does not in any way undermine the value of this ACNP's interventions with this patient. In fact, her presence as an ACNP in this service prevented the patient from "falling through the cracks." Her caring is evident in both her ability to use her knowledge in such a way as to intervene skillfully and in a timely manner, as well as in her concern for his welfare such that she did not leave him alone. Throughout her interview there were many evidences of her commitment to her patients as demonstrated through other caring behaviors.

> I often go back in the afternoon and will sit, not with every patient, but with some and try to spend some extra time either going over the plan, why we're doing what we're doing, why they're on this medication or that medication. And that's probably the more satisfying. It's more of that one-on-one patient interaction time. I like to sit down and, I'll talk to them and I'll say, "you know with what we were talking about before, this is what we mean by that," because they often will give the impression that they know what you're talking about but really they do want to ask more about it if they had the chance and felt that you had the time, because I think on rounds that they get the impression that oh we have so much work to do, whatever it is, can you keep it very brief.

However, these passages taken in context with the overall narrative and in association with several other ACNP interviews reveal that not all ACNPs practice in a patient-centered, holistic manner or within an act of generosity, where no reciprocity is required, even though it is espoused as their intention and alleged to be highly valued. Unquestionably, there were other demonstrations of the struggle to maintain their commitment to *being connected*. There were a few ACNPs who talked about "managing" their patients and their families, discussing them in terms of cases and/or diagnoses. They then listed the multiple reasons for not being able to enter into relations of care and the subsequent frustration they felt with feeling unconnected. The list included such reasons as the volume of patients to be seen, the expedient transfers from one unit to another, the location of offices relative to the practice settings, the actual time spent on-service given the number of ACNPs within the service, the "other parts of the job," that result in "less hanging around time" to be accessible to the patients and families. The serious question is whether any of the reasons for circumventing connectedness are *good* reasons. Why do some ACNPs need to care for the patient right from the time of admission to be connected?

> It bonds you if you were there when they were admitted and that's usually when they're the sickest or whatever; so that bonds you to them you know. You were there throughout this whole thing and you love them afterwards right, so then you can look after them more. Whereas you know you get this patient where you never met them before and things like that and then you don't have that bond anymore I think. That's much much harder.

Why are some ACNPs able to be connected despite being off-service, challenging spatiotemporal factors, early transfers, or multiple care providers?

> And I think for me to be able to tell them, "Well given the extent of her surgery, I predict that we'll see you on Monday and I will come and tell you these things and then by Monday

> we'll be probably in this place." I always make a joke with the parents talking about my crystal ball saying that it's actually quite murky, but through the murkiness I could expect that she would still be there Monday and that she would still be there for a good week for sure with us in the ICU. And then I make a point of meeting with them, even the day that I'm off- service, because I feel a certain connectedness with the parents, I make sure that when I'm off-service I will come up, say hi, and check on them. So I came on the Monday - I was off-service - so I came on, talked to them, they said, "Oh yeah, well we're about where you told us we would be," and they had a few questions, I answered those to the best of my knowledge, and also referred them to my colleague that's taking over for me for the details. And then I had them again this week for a few days and I spoke with them and kept them informed. And they feel very free to ask me questions, and that's very nice. They'll even come at some point in time and say, "Well when you have a minute we have another question and would you come?" And that to me is a very positive sign. They feel so comfortable that they can come and interrupt my work and they understand I have something else to do and say, "When you're done here, would you come for a few minutes and answer a question?" So they don't have to say that they appreciate my work or anything like that, but the fact that they feel comfortable enough to come, and that they're able to ask questions, and see where we are going, and even now that I'm off service again, I come back to see them, and I think they really appreciate that.

However, the role these external factors play as barriers to *being connected* should not be discounted in any way. Indeed, all ACNPs are challenged by a variety of situational issues on a daily basis, challenges that hinder engagement with the patients and families in meaningful ways. Yet, while many ACNPs are able to be connected *despite* these challenges, there are some who are unable to be connected *because* of them. Do these reasons reflect personal choice or the tendency to be drawn into the vortex that is modern technology? Could this struggle reflect medicine's treatment of patients in terms of what Heidegger (1959/1977) describes as "objects on call for inspection" (p. 297)? In a seminal critique of modern technology, Heidegger used the medical clinic as an example of a technology that transforms its patients into objects for inspection, "subordinate to the orderability of the clinic" (p. 299). Does the augmented use of technology that occurs within ACNP practice, particularly in combination with their enhanced engagement with medical practitioners, promote detachment? Certainly, several ACNPs described the seductive power of medical practice and how easy it is to emulate their worldview. Perhaps this is what is meant when Rilke spoke to "always hold to the difficult," even when the journey to *being connected* seems to be impossible. Perhaps by viewing the instrumental nature of ACNP practice as a dragon to be faced, ACNPs are challenged to view the dragon as a princess who is only waiting to see what is both beautiful and brave within them (Rilke, 1975). As Heidegger argued, we do not have to be prisoners of technology. "Perhaps everything terrible is in its deepest being something helpless that wants help from us" (Rilke, p. 99). Perhaps *being committed* to *being connected* both *through the use of* and *despite* the power of modern technology is the difference that ACNPs are able to make in their practice.

ACNPs reveal through their stories that providing information, support, and referrals, as well as promoting coping strategies, is often extended beyond individual patients to their families and support networks. ACNPs recognize that family members need comfort as well as information during their loved one's acute illness. Therefore, one feature that is highly characteristic of ACNPs' stories is the intensity of services provided to family and significant others. ACNPs strive to create moments with families to foster connected relationships. The simple things that are evident in these passages, as well as the others offered previously, make a humanizing difference to a dehumanizing experience. For example, the use of physical touch by ACNPs exemplifies how *being connected* is enacted in gestures that console far beyond what they accomplish during the practical components of treatment, just as the "touch of" nail polish mentioned earlier accomplishes as much or maybe even far more than the intrathecal injections of chemotherapy. *Being connected* is exemplified in the simple acts of stopping to chat, "touching base" on a daily basis, or staying behind to discuss concerns that are just "touched upon" in rounds. These are all acts of *being connected* and have the capacity to give to Others far beyond their practical significance.

> And what about those families who can't visit? I try and have daily contact with them in terms of giving them a medical synopsis of how things are going. And the first time they pick up the phone, "Oh it's the hospital" and you can just hear their breath at the other end of the phone, and then going, "Everything is fine." And I always try to use first names and, "He's fine. I'm just calling to give you an update."

> It's very common during bedside rounds that the doctor usually turns if the parents or mom are there and say, "Okay well da, da da, da da," and give them a little update, this is today or we changed this or we changed that and then of course they quickly have to move onto the next child. But it's very common for one of us to stay behind, even if it's not a nurse practitioner's patient, and I say, "Did you understand what he said, or do you have any questions about that?" I kind of check in with them and then if something doesn't go well, like on sign out rounds often we very quickly will give ultrasound reports to parents and if it's very bad the physician will often say, "I'll come and speak with you right after this," and then the doctor just says this or that and "we'll just follow it" and carries on; but if it's something that is minor to us, well sometimes the parents are just flabbergasted, and then I've seen my [NP] colleagues stop and take the time and even put an arm around the mom or something. And, it's just you never see a physician do that, not even a female physician, even if they thought it wasn't that appropriate for a man to do that to a mom, but even the women physicians don't do that. That's a nursing thing.

One immediately senses in these passages, as well as others offered heretofore, that ACNPs demonstrate their connectedness through their ability to be compassionate. Derived from the Latin word *cum* and *patior*, which together means "to suffer with"

(Barnhart, 1988), Leder (1990) indicates that compassion refers to an experiencing-with another, as in sharing another's experience. Like the word sympathy – derived from the Greek *sumpátheia* - it means that one feels something of the other's experience (Barnhart). In other words, one is able to recognize the experience of the other as a possible experience of oneself (van Manen, 1991). In being compassionate, the ACNP is justified in putting an arm around the mom or stepping away from rounds to spend time explaining or answering their questions and concerns. If one recognizes the power of information to create anxiety, uncertainty, and a further loss of control in the situation, then can it not be perceived as abandonment in the moment to simply throw out information and turn away? Instead, ACNPs foster a connectedness by helping family members to become partners in the care of the patients and empowering them when they lose their sense of control in the situation. In addition to the use of touch or simply by being present, they help the family comprehend the information given to them by simplifying it through an adaptation of the medical language. Ironically, using medical jargon and the medical mode of speaking with physicians in front of the families fosters the families' confidence in the ACNP as the care giver; however, it is when the ACNP translates that same information with an intentionality of respect and partnership, the interconnectedness between the ACNP and the family is deepened and strengthened.

Once again, the moral stance emerging in these situations is one of care, responsiveness to the Other through sensitivity to their vulnerability as a parent or spouse, sibling, or friend, and the preservation of that role within the patients' lives. These simple acts are gifts from one to the Other and create a sense of connectedness that demonstrates the ACNPs' commitment to bear witness to their suffering and their promise to be responsible for their safe keeping. These acts represent the ways in which the ACNPs strive to draw the families into a relation of care – "because care can only be a relationship, a dialogue not only of words but of touch" (Frank, 2004, p. 27), either literal or metaphorical.

> I'm again very focused on the fact that if I'm doing a procedure I always say to the family, "You stay. It's up to you. If you feel you need to leave that's fine, but if you'd like to stay, that's fine too." And most often the moms want to leave, but you know what, the dad's they like to watch because that's one thing they have some control over. And that's why one of the things I do when I bring a baby back from the case room, the dad comes with me, and we're on a different floor, so we actually have to go across a couple of pedways, up an elevator, and it's a long way. I get the dads, they always come with us, because they've got to see where baby's going, but I always get them to push the isolette. And my rationale for that is I always say to them, "You know what, I'm a lousy driver, and if you can do that," - and generally I'm doing something else anyways - it gives them something to do, gives them a little bit of control they don't have. They can't do much at that time but being able to

> push that isolette and see exactly where their baby's going makes a huge world of difference because then they can go back and report to mom and anybody else.

Being connected is about hearing the families' concerns and making attempts to address them in a timely manner. It is about making oneself accessible and available to them. It is caring about what matters to the family and believing that in helping the family address their concerns, the patient too will be positively affected. *Being connected* is *being committed* enough to work with and through others to help solve problems and ensure the implementation of a solution.

> We have a patient who's been in the hospital since March and he's been under various consultants and I've been responsible for him various times. But his wife has come in and talked about his needs that she perceives that he has. So for instance, for one reason or another, the patient hadn't been getting out of bed in a while and I guess I didn't understand why that was. And I went to the physiotherapist and said, "You know this patient really needs to be getting up at least once a day, ideally for meals." And so I talked with them and they seemed to be a little bit reluctant to get him up because we've got these special beds now which can be moved into a sitting position. And that's what's happened to this patient is that once they can get up into a sitting position, it's like they feel he's got up now, and they don't have to do anymore with him. But he's been stuck in his room in the sitting position. And we've got special lift chairs so that he could have been getting out of the room and going places. And so I did talk to them and the nurse about that and he is getting up now. So I think that's somewhere I've impacted where others may not, and it's my relationship with the wife because she knew that she could come to me with her concerns and I would act on them. Yeah, it's the little things. And this poor man's been in the room and he's had one complication after another, and if even for the wife, it's helpful that he's getting out of the room and doing things.

The clinical practice of caring for acutely ill patients in the acute-care setting involves communication and coordination with multiple specialty physicians, with various departments within the institution, such as radiology and pharmacy, and with outside community agencies. A large part of the ACNPs' practice is coordinating this complex system and *being connected* with the patient and family across and through time and place. *Being connected* is about creating constancy, consistency, and continuity with the intent to ease the burden that being within the health care system tends to cause and to ensure that patients and families do not get "lost in the cracks." *Being connected* is what Hawley (2005) has referred to as making the inhumane humane. The experience of being in the health care system is an experience of de-humanization (Gadow, 1980; Foucault, 1963/1994). The invasion of privacy, the infringement of autonomy, and being viewed as object and rendered invisible, is the experience of de-humanization and is real and ever present in health care as it is currently structured. What do ACNPs do that prevent patients from "falling through the cracks in our health care system"? What does this type of care look like? Perhaps this is best demonstrated in the following two examples of ACNPs and their practices.

In the first illustration, the ACNP is practicing in an infectious diseases subspecialty, with a particular focus on patients with HIV. She was concerned that there were groups of individuals who, for a variety of reasons "were falling through the cracks." These groups included "immigrants who had just recently moved to this country who really didn't know how to negotiate the health care system, who didn't have the language skills, or their culture in some way made it difficult for them work with our health care system, especially if they have an HIV label;" "those living in and out of the correctional system, with somewhat chaotic lives, and who don't have a lot of resources;" and "those with mental health issues who often find it difficult to work with the health care system." Yet all of these individuals need something extra. They need someone to "support them, to provide them with education around their illness, to deal with any problems that are related to their illness or treatments that they are receiving, to help them negotiate multiple care providers, and also to bring health promotion into the picture, dealing with smoking cessation, cardiovascular health, and dealing with substance abuse." These needs arise largely because "physicians who are very specialized in their knowledge don't deal with those things in their practice." As well, "the patient either doesn't have a family physician or the family physician refuses to see them once they repeatedly fail to show for appointments."

This ACNP recognized the chaotic nature of their lives and that for many of these individuals "their lives don't necessarily fit into a time structure" that appreciates the importance of "showing up" on time for prescheduled appointments. Thus, she created a "one stop care" practice. Although she set up appointments with them, "if they did not show up or were an hour late or they decided to come at four o'clock on Friday though they were expected at nine o'clock on Friday," she would still welcome and see them. As a result, she found "more and more of these patients call[ed] her directly because they [saw] her as their primary care provider." Eventually "the family physicians and other nurses in the community of public health [had] caught on" that she could see somebody in a short period of time. This ACNP did not work in isolation but rather negotiated this philosophy of practice with the other members of the health care team. Over time they became willing for her to create this alternative form of time embedded within the traditional time structure of appointments. "So everybody knows that I could be with somebody for a half hour or I could be there for two hours," and "when people come at weird times when I'm not expecting them to show up, basically what I do is I put things on hold and just say okay this is the most important thing to do right now and so I spend time with the patient."

In the second example, an ACNP working within a cardiac services subspecialty shared the story of a child and single mother with whom she had been involved from the time of the child's birth. The mom was described as "an eccentric character" "who had a mouth on her that could be as foul as any sailor coming into port," and "quite verbally aggressive with other health care professionals." Yet, she had been able to establish a trusting relationship with her that had been facilitated by "the whole sense of constancy and consistency" in the relationship. Despite having "come through surgery," the child was fragile, but as there was "really nothing that was being done for her in hospital that needed her to be there," she was discharged home. She "contracted" with the mom to see her at least once every two weeks and once a week if the mom felt she needed it. As she lived outside the city, the ACNP "called in a few favors" and "got the OT and the physiotherapist that [she] liked" to "agree to go out to the home to work with her, rather than having to bring her in." Due to a lack of community nursing support in the community, she made herself available on weekends to deal with "emergency issues," such as the accidental removal of the nasogastric tube or rehydration. When the child required surgery in another regional health care centre, she attended a family meeting at that institution "because there was so much difficulty" working with the mom. As she acknowledged, she had not "set this relationship up on purpose, but this was a necessary relationship for this particular mom, at this particular time." The ACNP "didn't want to negate their responsibility or negate their relationship with the family as being unimportant, but they needed to understand from this mom's perspective that is what was needed." As this mom stated, "'I need this person and I don't trust the rest of you; I don't necessarily need the rest of you, so help this work for me." This ACNP recognized that this mom was experiencing difficulties forming a relationship with any of the multiple physicians and nurses "who rotated constantly." Consequently, she made herself available over time and place.

Over time, the ACNP and the mom engaged in numerous conversations in which both "were asking some hard questions about whether this child was ultimately going to survive and if so for how long." They had "many, many discussions" about how she could die suddenly. Unfortunately, the child suddenly deteriorated at home and subsequently died on transport back to the regional center. Acknowledging that "there was only so far into the grief process that [they] could go together," the ACNP set up resources for her in her home community and ensured the social worker spent time with her as well. However, even many months later, the ACNP remained committed to returning the mom's occasional phone calls and they spend time talking over the telephone. The cardiologist told her, "We're done; we don't need to do any anymore." The social worker warned her, "Be cautious about why you are reaching out to her, because technically it's the social worker's professional job to do." But as this ACNP shared, "Here is a mom encumbered and wallowing in this grief process and what can I do for her?" As the mom so poignantly admitted to her, "Because I don't have a daughter anymore, I am no longer your concern." Yet for this ACNP "she was just as much the patient as the child was."

These two examples reveal that *being connected* through constancy, consistency, and continuity involves "worrying about" the Other and then acting upon that worry. They "work the system" through such actions as "massaging egos", "calling in favors", "crossing professional boundaries", and "negotiating with one's colleagues" for the chance to create time and space in order to better care for Other. *Being connected* is recognizing that care has "to happen inside of a relationship, which is different for a lot of families." For many patients and families, the "relationship is a professional relationship, in which they don't know much about you and you don't know much about them, and that's okay, and the care is outside of their own sense of well-being." But for some, as those described in the above illustrations, the care "happens inside a specific relationship, and if it doesn't happen inside that relationship, it isn't going to happen." *Being connected* allows for the patients and their families to define the relationship across time and place, "as long as it isn't outside the boundaries of ACNP practice." Consistency and continuity within ACNP practice allows for growing in caring from moment-to-moment. *Being connected* enhances the opportunities for knowing the person more fully as human beings in the process of living their hopes, dreams, and aspirations, and to use every creative, imaginative, and innovative way possible to assist the person to live more fully and to grow as human beings.

Being Content

The Oxford English Dictionary (Trumble & Stevenson, 2002) tells us that the word content, from the Latin word *contentare,* as an adjective means to be satisfied, pleased, gratified, and even delighted. From another orientation, the noun content, from the Latin word *contentum* is the sum of the constituent elements of something, the totality of the constituents of a person's experience at any particular moment. A closely associated word, contentation, from the Medieval Latin word *contentatio,* derived from the root *contentare*, means the allaying of doubt and the satisfying of the conscience. In everyday use, these three words tend to be treated as if they hold no relationship to each other; yet all three help us to gain a fuller understanding of what *being content* means for ACNPs.

First, *being content* with *being an ACNP* means ACNPs experience a sense of satisfaction and even joy with what it is they do in their clinical practice. Second, this experience of satisfaction is as a result of the sum of the constituent elements *of being competent, confident, comfortable, committed*, and *connected*, recognizing that the sum of the elements as co-experienced and interrelated are, as a whole, more than and different from the parts. Finally, in *being confident* with their competence and comfortable that they are able to embody their practice in a way that demonstrates *being committed* and *connected* as valued by them, their doubts about what they do and who they are allayed, in such a way that they experience a strong sense of doing what is both right and good. *Being content* is about finding a fit in *being an ACNP* or, in other words, discovering "a gold mine."

ACNPs begin this journey in a quest for something more, to find the "perfect fit" within nursing. Through perseverance and *being committed* to the journey, ACNPs eventually find a fit in *being an ACNP*. What ACNPs want is to do something manifestly practical in the clinical setting where they "stay close to the patient and their families." They find this in the direct clinical practice domain of the ACNP role. "It's doing, it's about diagnosing and coming up with the solution," about "the actual doing of the procedure," and "the sense of success when you have the line in the right place." "It's being able to complete the whole plan – the plan, the intervention and then the reevaluation of it and being satisfied at the end of it that the patient is in the best outcome that can possibly be." They no longer feel "constrained." They find a "level of independence that is quite adequate," "autonomy," and "added responsibility and accountability." They are "able to work collaboratively and build those partnerships with our medical colleagues," in a way "that feels safe." They are able to be "involved in every aspect of the patients' and families care," "by actually developing relationships with them over time." They are continually "challenged" and "recognized and valued" for what they do. In other words, they discover a "niche" in nursing. They are "glad" they have made the journey and believe they "have made the right choice." They are "happy with how it turned out," and have "no regrets." *Being an ACNP* "suits" them and they "feel satisfied." *Being content* affects the dialogical engagement with self and Others and as a consequence, they renegotiate the way in which they understand who they are as ACNPs in their practice.

ACNPs note that some of their ACNP colleagues are entranced by the medical realm and seem to leave their nursing values behind. When they do so, they leave the patient vulnerable. As one ACNP argued, "That's the danger of this role; like the Chinese say, opportunity and danger coexist on the same line." ACNPs share how easy it is to be "seduced by the dark side." Acknowledging that they do not mean to imply that medicine is "the bad side," they do admit that there is "a great deal of power associated with prescriptive authority and the language associated with ordering." For that reason, "being in a position of the one that people go to get stuff puts you in a position of power. You can choose to keep that to yourself or you can choose to share it. It is a struggle and sometimes it's just easier to be on the medical side." For some ACNPs, *being content* is only about having more autonomy, control, recognition, and power. To be seen as the captain of the ship or at least a welcome sailor is the desired fit. Aligning oneself totally with physicians is seen as a reasonable means to a desirable end, or allows ACNPs to "accomplish plans with others through access to traditional power sources" (Rafael, 1996, p. 13).

For many ACNPs the natural state of complexity that is inherent in the process of becoming and *being an ACNP* exposes, in the experiential nature of their practice, the contradictions within their experience, yet also provides the opportunity to reconcile them. For example, nurses drawn to the ACNP role have often seen nurses working at the bedside as invisible, not valued, and "impotent in effecting the social and political changes necessary to transform their clients' realities" (Rafael, 1996, p. 6). To acquire power, it is possible that some ACNPs distance themselves from other nurses by valuing knowledge and skills from other disciplines over nursing knowledge or totally aligning themselves with medicine. Power, in what Rafael has called assimilated caring (p. 8), is acquired by aligning with medical characteristics, practice, behaviors, and by assimilating medical norms. The ACNP who speaks with disdain at the physicians' inability to see the patients "crumpled up at the bottom of the bed" while on rounds, but subsequently "gets the nurse to reposition their patients so they're more comfortable while we're busy talking about their plan of care for the day" is a demonstration of distancing from nursing. ACNPs who, although expressing respect for nurses, echo the dominant medical discourse, which is that nurses' key skills are those primarily associated with information gathering and the means by which they carry out medical orders, also exhibit this form of distancing.

> And you know nurses just usually follow orders. They're there to gather the data that's needed. It's vital to have that information, but we're the ones who put it together and try to find the solution.

> I mean there's such a wide variety of nurses in the field and how they think. But many of them don't think, they just do what the procedures are, and they're not thinking about why they're doing it, because you'd think if you've worked here for five years that you'd figure out why you're doing that test, but I see it every day that some of them have no idea.

However, the cost of power obtained in this way can result in professional disunity, a further lowering of professional self-esteem due to horizontal violence, and a feeling of being marginalized. In addition, nurses' caring remains devalued, thus fostering a lived contradiction. In addition, Bates (1990), a physician, author of the classic physical examination text, and strong proponent of nurse practitioners, warned that "by expanding into medicine, nurse practitioners will need more than ever before to increase their consciousness of what nursing is all about. The values of nursing must not get lost in the dominant medical cultures. If they do, nurse practitioners justly risk the epithet of junior doctor" (p. 139).

Many ACNPs resist the dominant discourse that associates medicine with independence, cognitive logic, and aggression, and nursing with dependence, nurturing, and emotive logic (Rafael, 1996, p. 3). These characteristics are no longer viewed as conflicting concepts or as inferior ways of knowing and being. Instead, ACNPs demonstrate in their actions the power that comes from diversity, voice, nurturance, responsibility, knowledge sharing and choice, intertwined in a greater unity with autonomy, strength, mastery, and assertiveness. It is not denied that traditional "power over" may be used as a means to an end, such as to influence change in a health care system that is in need of change. However, there is a strong emphasis on mutual power that runs through this way of being, such that ACNP, patient, and other care-provides are transformed during the relationship, balancing out the "power between." Those ACNPs who argue that the question should always be - "What do the patients need, and not what do the docs need, not what do the nurses need?" - demonstrate the move from power being embedded in a division of labor that primarily serves the interests of those in power to power viewed as enabling, with opportunities for being equal in relations. Power as enabling is a relational way of becoming and being for these ACNPs. Power as enabling is demonstrated in the ACNPs' heightened awareness of interrelatedness and emerges as a sense of responsibility and generosity toward Others, both patients and professional colleagues. It is demonstrated in a practice that is informed by various forms of knowledge and skill and presupposes a growing knowledge base and clinical competence. *Being content* for these ACNPs is *being an ACNP* within this ontological, epistemological, and ethical understanding of power in praxis.

ACNPs talk about the number of times patients, nurses, physicians, and their own friends and families ask them, with the best intentions in the world, whether they feel "more like a nurse" or "more like a physician" in the administration of their practice. Do they live in the medical world or that of nursing? During the time of *Being Adrift*, ACNPs feel confused, unable to identify who they are or where they belong. However, in *becoming competent*, *confident,* and *comfortable* with the knowledge and skills required in the performance of their practice, embedded in a practice of *being committed* and *connected*, ACNPs begin to experience an inner transformation. They no longer resist the tasks traditionally associated with the medical world, nor do they dread the questions - who are you and where is your allegiance? In fact, as revealed earlier, ACNPs gradually experience a focus and intensity in their practice that is energizing and the potency of the synchronicity of knowledge from the nursing world combined with that from medicine is discovered and experienced as supporting the true purpose of their journey. They have endured the dark side of *Being Adrift* and overcome their fears by facing the most frightening places within themselves. As a result, an experience of *being content* enters into places formerly occupied by the burden of the struggle and the "incredible lightness of being" (Kundera, 1984). *Being content* is being renewed as a new way of being in nursing is discovered within each encounter in the practice setting. ACNPs discover all or part of the new dream or vision for their professional practice. How then do ACNPs respond to the questions – are you a nurse or a physician replacement? Where do you belong? "What side of the camp are you on, medicine or nursing?"

> You know I'm a nurse. I think building those core relationships with the nursing staff and making sure you are aligned with nursing is important. And it's very easy to slip into the physician's world, to align too closely with the physicians. And the physicians will say, "You're as good as a doctor," and they mean that as a compliment, but I say, "Always remember I'm a nurse. I do not want to be seen as a mini doctor." But, I also mean that I'm part of the physician team too. And so hopefully, I am the best of nursing and the best of medicine and I'm just broader, or rounder, but different. Is it a third mind set maybe? But I it's not necessarily separate, more of a joined mind set. But I think when you're in a NP role, you can really see more clearly, because one of the things that I found very interesting about being a NP was that it really helped me understand the physician role.

> It's the same place, you're the same person because I didn't change. I'm physically the same person. But I'm different yes and no.

Amin Maalouf (1996/2000), faced with a similar situation of being born and raised in Lebanon but living and working for 22 years on the soil of France, wrote that he always gives the same answer to the question - Is he more French or more Lebanese? - "Both." He explained that "what makes me myself rather than anyone else is the very fact that I am poised between two countries, two or three languages and several cultural traditions. It is precisely this that defines my identity" (p. 1). He challenges us with this question: "Would I exist more authentically if I cut off a part of myself?" Similarly, "Would ACNPs exist more authentically if they cut off a part of themselves? Are ACNPs half nurse and half physician?" Of course not. Identity cannot be compartmentalized. As Maalouf explained, "You can't divide it up into halves or thirds or any other separate segments" (p. 2).

Maalouf also shared that even after giving a detailed account of exactly why he lays claim to all his affiliations, someone always seeks to know what he truly feels "deep down inside." This question seems to reflect a widespread view of humanity which presupposes that "deep down inside" there is just one affiliation that really matters, a kind of "fundamental truth" about each individual, an "essence" determined once and for all when one belongs to a group or discipline. It is "as if the rest, all the rest – a person's whole journey through time as a free agent; the beliefs he acquires in the course of the journey; his own individual tastes, sensibilities and affinities; count for nothing" (p. 2). When ACNPs are asked who are they and where do they belong, they are meant to seek within themselves that same alleged fundamental allegiance. Having located it, they are then supposed to flaunt it proudly in the face of others. Is this not what the current debate about the role of the ACNP is about? Does the current discourse expounding the lack of allegiance to nursing through their engagement in "physician tasks" not marginalize ACNPs for claiming a more complex identity?

Being content is about resolving the tug-of-war or tension between their affiliation with the medical world that is in the process of forming on the one hand, and, their allegiance or strong and fundamental attachment to nursing, its people, history, language, geography, and philosophical foundations on the other. What happens in the journey that facilitates a shift in perception of self? What is different about the ACNP now? How does it happen?

In the way that Hegel argued, ACNPs follow a dialectical journey while engaged in the *doing* of clinical practice, during which internal contradictions are transcended, but give rise to new contradictions that also require resolution. Thus, it is not a linear journey but one that shifts back and forth, between an ongoing unmaking and remaking, shaping the particular experience of each ACNP. Frank (2004) has informed us that "*doing* is what counts, and knowing what counts as worth doing depends on being a person who has become shaped through discipline" (p. 53). ACNPs continue to define who they are by where they have been in nursing as well as where it is they are going in this role. By *doing* within a community of practice, ACNPs experience a change in their behavior and performance. They know themselves no longer as someone who only accomplishes the tasks of performing histories and physicals, diagnosing, or prescribing, but as someone who brings comfort to the patients and families, always recognizing them as persons with whom their care is entrusted and with whom they are in partnership. In *being competent*, *confident*, and *comfortable* embodied in *being committed* and *connected*, they are able to discover the difference they make. By recognizing and being recognized for making a difference, ACNPs find some or all of the "fit" for which they have been searching. They experience a new sense of belonging, and a sense of self is re-discovered in the act of experiencing their practice in a fuller way, and *being content* gradually comes to pass.

> The way in which I create myself is by means of a quest: I go out to the other in order to come back with a self. I "live into" an other's consciousness; I see the world through that other's eyes. But I must never completely meld with that version of things, for the more successfully I do, the more I will fall prey to the limitation of the other's horizon. A complete fusion…even if it were possible, would preclude the difference required by dialogue. (Clark & Holquist, cited by Frank, 2004, p. 46)

Over time ACNPs are enabled to interrupt their initial reactions experienced in *Being Adrift* and decide which judgments they choose to hold on to and which they will consider not conducive to becoming who they want to be (Frank, p. 53). With new knowledge of self being revealed in the act of doing practice over time, ACNPs no longer have to come to the questions - Am I either a nurse or a physician? Is my focus care or cure? Which side am I on? – from a dichotomous position.

In the book *Aidan's Way: The Story Of A Boy's Life and A Father's Journey*, the author, Sam Crane (2003), used fragments from ancient Chinese sages to make a figurative raft to keep himself afloat at a time when he was sinking after the birth of his disabled son. In much the same way, each moment in which ACNPs make a difference in their clinical practice engages them in a personal dialectic and as such those moments serve as a raft on their journey. Each moment of making a difference as a result *of being competent, confident, comfortable, committed*, and *connected*, provides the measure of what counts. Each moment from their ordinary, day-to-day practice adds resonance to their personal journey, connecting their struggles and discoveries to an understanding of how to live as ACNPs and how to understand who they are. These moments of making a difference become a source for reflection. In other words, these moments called upon in a dialectic engagement have their fulfillment not in definitive knowledge but in the openness to experience that is made possible by experience itself (Gadamer, 1960/1989, p. 355). These experiential moments suggest which ways of understanding and acting they should cultivate and which they should avoid in their practice. The values ACNPs uphold become self-disclosed as well as made evident to others. By *being committed* and *connected* in their practice using their new knowledge and skills competently, confidently and comfortably, they effect their own re-presentation of who they are as ACNPs through the way they do their work and relate to others. They reveal the moral framework in which they choose to live.

Being content means that ACNPs realize that *being an ACNP* does not require they abandon a nursing framework of care. Although medicine and nursing are still distinct, they are no longer viewed as mutually exclusive in terms of the clinical care they provide. ACNPs' stories are replete with moments of both care and cure and their performance in both the nursing and medical domains. The medical domain contains diagnosis and treatment of diseases. The nursing domain contains consideration of individual and family responses to actual or potential threats to health and involves helping patients cope with disease processes that might be occurring. The ACNP anticipates human distress and works on the level of what an illness experience means to the patient and family. The degree of detail provided in their stories of their patients and families are calling upon all of us to stay with them and understand them as ACNPs who bring together two traditions of thought. In fact, they take place together; they are two constituents intrinsic to the process of the negotiation of not only how to care for their patients, but also the meaning of who they are as ACNPs. The complementarity of nursing and medicine reflects the fundamental inherent duality of who they are and what they do as ACNPs in clinical practice. This duality is a fundamental aspect of the identity of *being an ACNP* and perhaps is better appreciated in Lewis Carroll's (1865/1971) whimsical reminder of this notion when Alice is forced to ponder the sides of a mushroom.

> Alice waited patiently until [the Caterpillar] chose to speak again. In a minute or two the Caterpillar took the hookah out its mouth, and yawned once or twice, and shook itself. Then it got down off the mushroom, and crawled away into the grass, merely remarking, as it went, 'One side will make you grow taller, and the other side will make you grow shorter.'
> 'One side of what? The other side of what?' thought Alice to herself.
> 'Of the mushroom,' said the Caterpillar, just as if she had asked it aloud; and in another moment it was out of sight.
> Alice remained looking thoughtfully at the mushroom for a minute, trying to make out which were the two sides of it; and, as it was perfectly round, she found this a very difficult question. (p. 46)

In other words, there is a recognition and reconciliation that the perspectives from both nursing and medicine are necessary and enable each other. *Being content* with *being an ACNP* means that ACNPs recognize and accept that the nursing and medical perspectives are a unified duality. On the one hand, it takes their participation in the medical world to learn and use the knowledge and skills necessary to care for their patients in a broader and deeper way denied to nurses in traditional nursing roles. There is an intense involvement with the medical components of clinical practice, such as making a medical diagnosis and prescribing. On the other hand, their continued intense participation in the nursing world is needed to generate meanings that reflect nursing enterprises and nursing's take on the world as they interact and assist their patients and families in interpreting the meaning of the illness event. Simply stated, "medicine and nursing" are two dimensions embodied by the ACNP that interact; they do not define a spectrum, for to regard them in this way is to still see a relation between opposites, where "moving to one side implies leaving the other. More of one implies less of the other" (Wenger, 1998, p. 66-67). However, as Wenger illustrated, with an interacting duality, both elements are always involved, and both can take different forms and degrees. In fact, the ACNPs' practice can be construed as stemming from their ability to bring the two together.

This does not mean, however, that ACNPs want to "dissolve" their identities "in a kind of undifferentiated and colourless soup" (Maalouf, 1996/2000, p. 21). Simply stated, medicine and nursing imply each other in *being an ACNP*; they do not substitute each other. Increasing the level of medicine or nursing does not dispense with the other. On the contrary, it will tend to increase the requirement of the other. With an interacting duality, nursing and medicine, when embodied in ACNP practice, transform their relation to each other; they do not translate into each other.

Wenger (1998) avowed that a binary or dichotomy "tends to suggest that there must be a process by which one can move from one to the other by translation into a different but equivalent state" (p. 68). For example, when ACNPs prescribe, their actions in a dichotomous perspective are either ascribed to those of a physician substitute (and subsequently their identities would be translated as thus), or, the prescriptive act is interpreted merely as a tool in the nurse's hands, passed on by medicine in a similar manner as those skills previously held exclusively by physicians (e.g. the use of a stethoscope or sphygmomanometer). By contrast, a change in the relations of nursing and medicine within the same role always transforms the possibilities for negotiating meaning. Participating in the medical world is not just a functional enactment of a set of prescribed tasks, but a renegotiation of what it means to be a nurse in this new context. In fact, engagement in these medical activities creates the conditions for new meanings. Perhaps *being an ACNP* is being in a frontier zone criss-crossed by knowledge, skills, language, and geography. But by virtue of this situation – peculiar rather than privileged – ACNPs have a special role to play in forging links, eliminating misunderstandings, smoothing out difficulties, seeking compromise. *Being an ACNP* means having the ability to be a bridge, a go-between, a mediator between the various communities and cultures (Maalouf).

> And they say, "Are you more like a doctor or are you more like a nurse? And I say, "Well I'd say kind of somewhere in between." But I'm still a nurse. I see a gap, I bridge it. So, sometimes I feel like a bridge builder.

Ted Aoki (1996/2005), a prominent Japanese Canadian avant garde pedagogical scholar, cautions us to stop and reflect on what is meant by the term bridge. Like the experience of Maalouf and ACNPs, Aoki demonstrates that by placing quotation marks around "nurse" and "physician" insistently reminds us that both terms are rendered as a binary of two separate pro-existing entities; yet they can be bridged or brought together to conjoin in an "and" when we speak of "nurse/nursing and physician/medicine." Aoki speaks, however, to the unstable identities that the quotation marks around the proper names "nurse and physician" signify. From one viewpoint being a bridge/bridging could be seen as ACNPs acting in ways that expedite service, helping patients to move from one place to another in a speedier fashion, thus retaining an instrumental form of being. Such a perspective has implications for nursing, medicine, and administration at a variety of levels. An excessive emphasis on the formalization of the medical world (i.e., the knowledge, skill, and authorization) without corresponding levels of formalized acknowledgment of the nursing expression of the role would in fact result in an experience of meaninglessness for ACNPs. Conversely, a neglect of explanations and formal structures necessary to enable the enactment of the medical components of the role would also result in this same experience.

Clinically managing the patient as an ACNP always rests on participating in the medical world: what is said, represented, or otherwise brought into focus in clinical practice must now always assume a history of participation in this world as a context for the interpretation of how they are seen by others, how they see themselves, and how they enact their role. In turn, how they enact the role, as well as how their identity is shaped, always organizes itself around nursing because the ACNPs come to the role always deeply rooted in their nursing history (i.e., the artifacts, language, and concepts that shape nurses' values and beliefs).

Thus, in *being an ACNP*, nursing is not freed from medicine. In fact, in terms of meaningfulness in becoming and *being an ACNP*, the opposite is more likely. To be understood and to understand one's self meaningfully, *being an ACNP* requires that there be a close connection to the medical community, while not obviating the enactment of the role from a nursing perspective. One only has to recall the illustration of those ACNPs who have been obstructed from participating in the medical world (i.e., they are prevented from enacting the medical components of their role, such as prescribing or performing medical skills they have been trained and licensed to do, or have been asked to step aside when residents are available), to know there is less meaning to their role, not more. Likewise, when ACNPs are unable to assimilate their nursing world into the medical one (as in *Being Adrift*), they too experience less meaning to their role, not more. Rather, Aoki encourages us to view bridge/bridging in a Heideggerian sense, as "a site or clearing in which earth, sky, mortals and divine in their longing to be together belong together" (p. 316). From this viewpoint, *being an ACNP* means that the bridge is a dwelling place for ACNPs; it is a space between nurse and physician.

> I guess I live in my own world. And the NP takes all of the nursing and that extra bit of medical knowledge and comes together somewhere in the middle.
>
> And I think we're in that middle ground. I really believe we're in our own ground.
>
> I am not a physician extender. I have a whole scope of practice that's separate from theirs. It's like two circles that cross sect and there's a shared segment but we both have sections outside of that shared section that we need to be able to deal with. And maybe I'm supposed to be in that section. Because if we are so tied to the physician that our sections don't intersect but totally overlap, then we'd all be the same and that wouldn't be effective.
>
> And I'm always between nursing and medicine, always, always, always. But it's not always a conflictual thing. ...It's not always an uncomfortable place. It is the place where I live. I am a nurse, yet I've got this medical training. I order tests, I read tests. That's not a nursing task, yet I do some of the parent comforting, I do some of the nursing teaching. So I'm

> always in-between and it's most often not an uncomfortable place. It's an okay place to be. And sometimes you don't feel you belong, but sometimes you do. …Where do I want to belong? I'd like to belong to both I guess. I like my attachment to nursing. I like the way nursing looks at patient care. I like the way nursing is holistic. Nursing is who I am. …And I feel I have a good attachment, which is different that when I was a staff nurse, to the nursing staff. I also feel that I have a privileged relationship with my fellow attending physician and the fellows. Do I belong in either group fully? I don't think so. But that's okay.

When ACNPs state that they feel like they are "neither," or "both", or "in no-man's land," and even for those who have found their existential place of being in nursing with the use of medicine, perhaps they are trying to articulate Aoki's image of "crossing" between East and West. Aoki (1996/2005) writes that to loosen his attachment to East or West as "thing," he has called upon the Chinese notion of "nothing" or "no-thing" (p. 317).

> But I note that in "no-thing" there is already inscribed the word "thing," as if to say "nothing" cannot be without 'thing'," and "'thing' cannot be without 'no thing'." For me, such a reading is already a move away from the modernist binary discourse of "this and that," or that imaginary grounded in an essence called "thing." And now I am drawn into the fold of a discursive imaginary that can entertain "both this and that," "neither this nor that" – a space of paradox, ambiguity and ambivalence. (p. 317)

If *being an ACNP* is reframed as belonging to both nursing and medicine, or, to neither nursing nor medicine, and if "and" is re-understood as "both 'and' and 'not-and'", as Aoki (1996/2005) has articulated, this allows a space "for both conjunction and disjunction" (p. 318), with bridges being both bridges and non-bridges. ACNPs' ontological being can be rethought of as a space that is a third space between nursing and medicine. Perhaps this is a new way to consider the meaning of the term "no-man's land," or "my own world," or "the middle ground," to which some ACNPs refer. And then, as suggested by Aoki, "identity" is viewed as a "becoming in the space of difference," "a generative space of possibilities, a space wherein in tensioned ambiguity newness emerges" (p. 318).

"Far from being eternally fixed to some essentialized past" (Stuart Hall, cited by Aoki, p. 318), ACNPs are subject to the continuous play of histories, culture, and power. This does not mean, as Maalouf (1996/2000) has noted, that there will not always be a certain hierarchical valuing among the elements that go to make up the ACNPs' individual identities. However, this hierarchy is not immutable; it changes with time. In this light, ACNPs are viewed in a space of *being content* with *being an ACNP*, because in this space where ACNPs share linguistic, geographical, and other cultural elements of both nursing and medical worlds, "a hybrid of both individual identity and doubled identity" (Aoki, 318) is created. Perhaps this is what Brykczynski (1985) meant when she wrote the NP is the true hybridization of nursing and medicine (p. 5).

> Hybridization does not necessarily mean decline through a loss of identity; it can also mean empowering existing identities through the opening of new possibilities. Only a conservative identity, closed on itself, could experience hybridizationas a loss. (Ernesto Laclau, cited by Aoki, p. 319)

Indeed, Aoki's imagary allows envisaging of this meaning of bridge as a third space between the worlds of medicine and nursing, between and among diverse segments of nursing, or between and among diverse segments of medicine, as spaces of generative possibilities, spaces where newness can flow. This allows for the experience *of being content*.

Seeing the patient as the center of focus while being in this third space, *being an ACNP* can be understood to mean building bridges between one discipline and another, one part of the health care system and another, observing both banks of the river, taking an active part on both sides, and having an identity that is both and not-both. Viewed from this perspective, this is precisely why the unification of dualities is so significant and possibly why ACNPs should not be pressed to take sides or ordered to stay totally within their own discipline. Perhaps the words of Anne Fadiman (1997) in her book, *The Spirit Catches You and You Fall Down*, reflect these thoughts more eloquently and help us to understand why ACNPs can experience *being content* in this space:

> I have always felt that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one. (p. viii)

Several concrete examples from the ACNPs' world, as heard in their voices, are offered. They bring to life the reality of being a bridge/bridging as an in-between or third space that creates new possibilities.

> Last week I tried to get some obstetrical care for a pregnant patient and the obstetrician just could not see the reason why she should come in. And even though I tried to explain to her that this patient, despite all the other reasons that she was with us in the PICU, needed obstetrical care, and just regular prenatal care, that's all I wanted, this person just would not see the point. She just couldn't see the point that this was good patient care, and that this whole patient here, who had many challenges ahead of her, one of them was that she was pregnant. And theoretically it should be easy to meet this child's need. You get an obstetrician, you get her followed. But this consultant just would not get it, and refused to come and see this patient and this was a challenge for me because the patient was not getting the care that she deserves and needs. But it did get resolved in part; the story is continuing to unfold. I involved the obstetric nurse who does some part time parent counseling in our unit - she has a part-time, divided job, which is very convenient, between adolescent medicine, which follows all the pregnant teenagers, and PICU. So I did speak with her and, said, "Well how are we going to get to do this?" And finally we decided that she would start doing some of the workup of antenatal care, and she would negotiate with

> the obstetric team to follow this child. The child's been transferred but this remains a concern. I am still working on this even though the patient's not here with me anymore, because I think that's too important to be left.
>
> Nurses still perceive me as one of them. There are many situations in this unit where nursing and medicine see things differently and that I think, in this unit anyway, is historical. So nurses tend to more quickly want to move towards palliative care or comfort care and we'll question more frequently why we keep going, and for medicine, as long as we haven't exhausted all the avenues then we're not done. So I'm a bit between and that's very demanding psychologically too. The nurses will ask of me to do something and when I go and talk to an Attending he'll say no. And I'm sort of stuck between. And I can understand what the Attending is telling me and I can understand what the nurses are telling me. So for example, a very frequent issue is comfort. Nurses are very pro comfort. Physicians are pro comfort as long as they don't want to extubate. …And physicians will say, "Well turn off all the sedation and let the kid wake up," and the nurses are the ones literally sitting on the kid and seeing this child cry and being uncomfortable. And sometimes they see me a bit as a traitor because I'm the one who actually writes the order – stop, d/c sedation. … So I'm seen a bit as a traitor by the nursing team but sometimes the medical team sees me a bit as a traitor too as "Stop being a nurse now." And I'm not saying they don't get it, but they don't get is as much because they have never sat on a child that's trying to extubate himself when they're not ready, or see the child cry or just be agitated, or see the parents cry at the bedside. But I can see that both parties need to be defended. So I go and see my Attending and I say, "Well you know I don't think we should stop sedation because this kid's been on it for so many days," and I try to negotiate. Usually I get part of what I want at least, and when I come back to the nurses I can say, "Well okay we got them to half the sedation rather than stop it". And there's times where it's stop the sedation and I can understand what the medical rationale is, and I know that the nurse at the bedside doesn't see the full picture, and that comfort issue is not an issue at this point in time, and that we have to move on. And I think trying to explain to them what it is, trying to explain to the bedside nurse, and trying to also say, "Well if we get into trouble, I'll be there and I'll try to find a solution for you." I think that with nursing, it's trying to see if we can find another solution and with medical it's trying to negotiate.

Being an ACNP represents an enriching and fertile experience when ACNPs feel free to live fully – when they are encouraged to accept their clinical practice in all its diversity. But it can be hurtful if they are met with looks or words of incomprehension, mistrust, and even out-right hostility whenever they claim to be nurses. It can be hurtful if every time they emphasize their ties to the medical world other people look on them as traitors or renegades. Remembering that one's identity is a negotiated experience, a nexus of multi-memberships, and a relation between the local and the global (Wenger, 1998, p. 149), people's attitudes must allow for multiplicity to foster ACNPs' *being content*, or their being able to accept this composite identity tranquilly.

Being content does not mean that the journey comes to an end, even for those ACNPs who have found the "perfect fit" in *being an ACNP*. One only has to recall Homer's (1996) Odysseus on the Isle of Circe, to be reminded that a journey continues because the call for more beckons and/or there is an external push to pursue the search for more. After many years of bitter wanderings and woes suffered upon the seas, Circe urged Odysseus to stay on her Isle to rediscover the man he had been before he left Ithaca. He stayed with this Goddess for well over a year, forgetting to mark the passage of time, content with the fine food and honey-sweet wine, spellbinding songs, and enchanting women, until one day his men came to him to remind him that Ithaca called and that they needed to return to their homes. Then he too remembered his people and his obligation and began to look for the opportunity to continue his journey.

> It was so long since she had been anything near the right size, that it felt quite strange at first; but she got used to it in a few minutes, and began talking to herself, as usual, 'Come, there's half my plan done now! How puzzling all these changes are! I'm never going back to my right size: the next thing is, to get into that beautiful garden – how is that to be done?
> ~ Lewis Carroll (1865/1971), *Alice's Adventures in Wonderland*, p. 49

CHAPTER SEVEN

BEING PULLED TO BE MORE

Gadamer (1962/1989) argued that our being is fundamentally temporal, that is, the work of being and becoming is always ongoing. This is never more evident than in the lived experience of ACNPs. This temporality of being ACNPs is more complex than just a linear notion of time because *Being* is always constructed in a social context (Heidegger, 1927/1962) and is defined with respect to the interaction of "multiple convergent and divergent trajectories" (Wenger, 1998, p. 154). Finding the "perfect fit" is one such trajectory and the dream of what that "fit" could be provides the context in which ACNPs determine what, among all the things that are potentially significant, actually becomes significant learning and activities within their role. This sense of trajectory, albeit not a course that is charted or even foreseen in all its variations and permutations, gives ACNPs a way of sorting out what matters most and what does not, what contributes to their being, and thus their identity, and what remains marginal. ACNPs are always simultaneously dealing with specific situations, participating in the histories of certain practices, and are always involved in becoming certain persons. The journey in which they participate incorporates their past and their future in the very process of negotiating their present. It is influenced by that which they wish to be and that which others want them to be. Sometimes there is congruence and other times tensions or conflicts; but either way, both internal and external struggles are experienced. Never is this struggle more illuminated than in *being pulled to be more*.

As a result of the experience of *being competent, confident, and comfortable,* ACNPs begin to experience *being pulled to be more*. It is important to reinforce that the time of *being pulled to be more* does not seem to emerge into their consciousness as an increasing tension or struggle until *Being an ACNP* is experienced. The "first and only priority" for ACNPs when they initiate their journey is necessarily the clinical management of their patients. Keeping their focus entirely on "learning all [they] need to know in the clinical area and to become comfortable doing this kind of clinical stuff" "takes a long time." This is best illuminated by one ACNP in her fourth year of clinical practice. Throughout the interview, she expressed mixed feelings about her level of expertise in the clinical area and her ongoing development as an ACNP. She described herself as barely at the point where she could even engage in the reflective process of what it meant to be an ACNP and what had shaped her development. As she so perceptively pointed out, "it's not any one thing, just everything, and nothing" that has influenced who she felt she was at this point as an ACNP, for as she noted, the entire first two to three years were "a bit blurry" as she struggled to develop competence, confidence, and comfort with just the clinical component of her role.

> You know you spend the first year just coping; so you spend the first year trying to keep your head above water, trying not to kill anyone, and trying just to get comfortable, that's your whole first year. And to even suggest you could do education or research the first year is ludicrous in my opinion. The second year you kind of hone and refine your skills, and not just physical skills, but just your whole diagnostic reasoning skills. So you're comfortable on-call now by yourself but you just are refining everything and making everything a little bit smoother. And then it's not until the third year that you can look outside of yourself for these, I believe, defining moments because they actually can impact on you then. Does that make sense? You can't even take it in before then really. And I think that that's the point too where you have so much more to give and you're ready to take on more in the role and you're ready to mature. ... So I'm just barely there; I'm just to the point where I can consider and maybe even do more.

As revealed, ACNPs gradually experience and admit to the routine, sometimes even mundane, nature of the direct clinical care they provide. Depending on the nature of their practice, such as the complexity and variability of patient care, years experience with the patient population prior to becoming an ACNP, and the relationship with their physician group, it does not seem unusual for it to be three to five years into practice before they can contemplate undertaking other types of work within their practice.

> Some of the time is very routine, yeah to be honest with you. ... I really felt like a novice in the role initially even though I'd already been at [hospital] for three years. I think that at the five year point I began to feel there was like a routine nature to the role and I could do more.

> Neonatology is quite a narrow field; there are some 'kind of out there' disease conditions but they're extremely rare, so you're dealing with a subset of problems that are quite routine and so you can get quite comfortable at dealing with those I think and then others begin to expect more of you.

It is easy to understand that as ACNPs become more efficient and effective in the clinical management of their patients, time and new energy becomes available for them to use in new and different ways. As one ACNP noted, when "things begin to run like a well-oiled machine" there seems to be "more time to do other things like committee work, education and research." ACNPs now find themselves thinking about taking on more and different responsibilities in their role. But similar to the initial call in *Being Called to Be More*, *being pulled to be more* arises from a variety of internal and/or external sources or callings.

"They began to give me administrative roles initially. Mostly it was committee work that I had. I think after about four years they gave me responsibility for doing policies and procedures. And now I'm expected to do some element of staff education." For some

ACNPs, the pull arises from external sources. These ACNPs find themselves being "told" or "given" added responsibilities by nursing management. Despite acknowledging that the ACNP role has been "set up" to include "a clinical portion and to be responsible to do some education, some administration, and a small expectation for research," life as an ACNP is experienced as being "only so big" and "you can't get it all in." From their standpoint, expectations emerge from nursing management that, "given [their] salaries are being paid from the nursing budget," they "need to do things other than just the patient care;" "they need to contribute back to nursing within the organization or to the program."

From this view of their world, the concept of owing the system arises; that is, ACNPs owe something more than their work at providing patient care and meeting the patients' clinical management needs. However, some ACNPs discover that for which they have been searching in *Being an ACNP*, that is, *being more connected*, *more in control*, *more visible*, and *more challenged*. They already experience a sense of freedom, exhilaration, and satisfaction with their ACNP role. For these nurses, they have found the "perfect fit" in *Being an ACNP*. Consequently, *being pulled to be more* is experienced as an irritant to be managed and contained because these "extra" role functions become an interference with the clinical "hands-on" work they so love to do. As one participant shared, as a consequence of "trying to fit in the other parts of [her] job, she has "less hanging around time" in the unit to be available to meet with families.

> Well you know there's always this struggle. Most of the people who stay in this role I think their primary interest is in patient management and so if you try and get us too far away from that we're not going to be very happy. Well how much time do you spend doing this and how much time do you spend doing that? Well of course your patient needs are paramount because you can't just leave them be, so they probably take more of your time than what some of the managers would want you to, but from my point of view I kind of like that because that's why you're here. You like to do the extra things on the side, but, then they [nursing management] say, well we have this many people so this is how your role is going to be.

> [Nursing management] wants to see more output and I think that just becomes a function of any administration. If they're putting out a lot of dollars into some position then they want to see that the name of the institution or whatever is highlighted throughout the world. So it isn't enough to give good patient care, you have to be documenting it and publishing it. So they're making a push for that now.

As a result of the tension experienced, resentment toward management surfaces and frustration at not being understood builds. Nursing management becomes perceived as "they," with power over their time management and the focus of their energies. For these ACNPs, fear about replacement arises and is compounded by their perception that the physicians with whom they work have little power to intervene on their behalf. They are aware of "the talk about foreign graduates who can't get on as physicians but who could become physician assistants," and the consequent "negative impact this could have" on the ACNP group if they "can't meet the service component of the job."

> [Reporting to the nursing director] I think is one of the difficult issues of nurse practitioners because at least over half of your time is kind of more in the medical kind of things, but the physicians only have a side limited ability to influence. They can influence who's hired but no nursing discipline issues or ongoing things. They have a very limited role in it because the money doesn't come from them....and so in the end it doesn't become their decision where we spend our time. So even though you're working with physicians and you're doing this kind of job, they have very little influence over us and so it's kind of funny that the job is kind of half this and half that.

Having found the "perfect fit" in the clinical component of the ANCP role, these ACNPs fear replacement by other professionals if they assume "other" or "too many other" responsibilities. Doing hands-on patient care and making a difference by being readily available to meet the patients' and families' needs in a timely fashion is judged to be compromised when they are engaged in other activities that are "less visible," and therefore, less valued by the staff nurses and physicians within their service.

Wenger (1998) reported in his work on communities of practice that work that is less visible than the more instrumental aspects of practice can easily be undervalued and even totally unrecognized (p. 75). As a result, some ACNPs struggle to become engaged in activities that, although desired by some within the more global institutional nursing community, are judged to be of less value by the local or immediate community of practice and self. In fact, for these ACNPs, "being pushed" or "decreed" by the "organization" to "have more research coming out" of this role "violates the definition of nurse practitioner." Concerned that "the organization" wants to make "a specialist" out of them, it is revealed that research, education, and leadership responsibilities are perceived as domains of practice that belong to the CNS role.

> And if we don't fill that hole and they have to find somebody else then perhaps they won't need us any more, so you know we don't mind filling the holes. But then there's that tension between management who don't want you just to be patient management because anybody could fill that role, and that's true. You have to do these other roles to make it unique to nursing kind of a deal. So there's that constant tension between the two of how are you're going to spend your time.

> The Operating Officer of this hospital believes in nurse practitioners but not strictly as a patient management role because then that could be physician's assistant or something like that. Somehow this has to be uniquely nursing and I can buy that. But then what is the split? ...So our manager is saying, 'I think that you spend too much time on the patient management and I want to make sure that you have time for these other roles to make it whatever.' But I'm just thinking, well make sure that you meet the program needs because if you don't then they will get physician's assistants and then we'll be unnecessary, and

> that's not a good thing for us. ...You can't work that way. If you want the job and you say that you can provide this type of care and yet at the drop of the hat you just let everything go, can you see where people might perceive you as not that important? Like if you're not there to provide the service then somebody else could do it because obviously you're letting them do it.

Why do some ACNPs fear replacement by other professionals? There can be no denying that there is a strong historical foundation that underlies their fear. Memories are not so short as to forget that just over twenty-five years ago funding for NP educational programs and monies to employ them in the primary health care sector were withdrawn by the Ontario Ministry of Health, the first province to initiate the NP role. Hundreds of newly trained NPs found themselves unemployed as a surplus of new medical graduates emerged on the scene. NPs, perceived merely as physician replacements, were no longer needed or wanted. It is also a fact that some newly "qualified" ACNPs find themselves replacing nurses who have been "allowed to do advanced roles" without adequate qualifications and consequently have "had their jobs cut back." Many nurses seized the opportunity to become ACNPs because their CNS positions were declared redundant due to perceived lack of cost-effectiveness, only to find this role being replaced with case managers, clinical resource nurses, and others. Registered nurses working at the bedside have been repeatedly downsized, being replaced with registered practical nurses and patient service workers. Current professional and public discourse remains replete with controversy regarding the need for NPs, and NPs are being encouraged to promote themselves as a "cheaper" alternative to other health care providers (AANP, 2002; CNA, 2002c). The use of physician assistants (PA) as an alternative to ACNPs is another current discourse emerging on the Canadian scene, an appealing option for physicians who retain control over PAs' activities and at less cost. Therefore, is there a possibility that this fear, also discussed by Pearson (1990, 1995), connects with the discourse on "owing" something more to the organization? Owing not only implies that one has an obligation or duty to give something of equal value back in return for something received; there is also an inherent sense of being owned or of belonging to another in an instrumental and economic way that can arise out of this obligation.

Why does the organization believe that ACNPs owe the system more than what they already do in the clinical domain of their practice? Does this reflect the overall devaluing of hands on care that arises from the nursing role? Gadamer (1962/1989) argued that we interpret and understand ourselves and others through the world's reflection as revealed in discourse. Current NP discourses have resulted in the NP being constituted as an object of nature and therefore understood metaphorically as a tool or instrument within the health care system to be used efficiently and effectively (Rashotte, 2005)[21]. Perhaps Heidegger's philosophical work on the essential nature of technology can help us to better understand why these views dominate the discourse on the NP, as well as reveal how some ACNPs experience their role and negotiate their identity through dialogue.

Taylor (1991), in "*The Malaise of Modernity*," argued that when a society redesigns itself on the value and beliefs of individualism and autonomy (i.e., happiness and well-being of individuals) instrumental reason becomes the yardstick by which success is measured. Consequently, individuals become vulnerable "to being treated as raw materials or instruments for our projects" (p. 5). Heidegger (1959/1977) argued that technology imposes a particular sorting, ordering, commanding, and disposing of nature and man (p. 14). Although such an encounter is a *revealing* one, modern technology pursues this in a *challenging* manner (p. 14). It seeks to unlock, transform, store up, and distribute concealed energy from nature and man (p. 16) and order it into a *standing reserve* stockpile (p. 17). The result of this stockpiling is that modern technology orders everything and everyone to stand by (p. 17), to be always ready to be used for something pre-chosen (p. 17, 23), and to be on call for a further doing (p. 15).

Heidegger (1959/1977) argued that the essence of modern technology is to seek to order everything so as to achieve more and more flexibility and efficiency: "Expediting is always itself directed from the beginning …toward driving on to the maximum yield at the minimum expense" (p. 15). Our only goal is optimal ordering for its own sake. Heidegger concluded: "Whatever stands by in the sense of standing-reserve no longer stands over against us as object" (p. 17). For example, ACNPs are not individuals who engage in meeting the needs of the patients as worked through in the NP-patient relationship, but rather are manipulated by the system to do its work. In essence, ACNPs become a resource, not only to be used, but also enhanced. "Man, who no longer conceals his character of being the most important raw material, is also drawn into this process" (Heidegger, cited by Dreyfus, 1993, p. 306).

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[21] A version of this discussion has been published. Rashotte, J. (2005). Knowing the nurse practitioner: Dominant discourses shaping our horizons. *Nursing Philosophy, 6*, 51-62.

In this age of modernity, ACNPs have come to be constituted as a machine or tool to be scrutinized for its uses and efficiencies within the work place. This discourse allows ACNPs to be thought of in terms of what the role is, but not in a way which provides a space to know who the NP is, their interior life, and of what it means to be an ACNP. In becoming an object, the ACNP as a tool has been separated from the essential person as an ACNP. The full measure of what ACNPs have to offer their patients has failed to arise in the discourse and therefore remains invisible. Consequently, this way of being may be interpreted as less valuable and only those activities that are identified in dialogue with others are perceived as being valuable enough to retain them in the system. The dominant discourse, for instance, has not made visible the time and skill it takes to be physically, personally, and existentially available to the patient. The ACNPs' "hidden riches" (Dreyfus, 1992, p. 177) as brought into the light in *being an ACNP* have failed to surface even at the institutional level for many ACNPs.

There are traps inherent in viewing and being viewed from an instrumental and economic viewpoint. One trap is the power of technology to direct human action (Bergum, 1996). Danger arises when individuals become mere objects, managed, and controlled as the means to accomplish technological ends (Gadow, 1994) because they too begin to view themselves from this perspective. It is no wonder that some ACNPs feel like a "puppet" on a string whose movements are controlled by the whims and fancy of the puppeteer. The external forces, such as nursing management and physicians, can force an adaptation and flexibility that results in an experience of being more controlled rather than *being more in control*.

The analogy of feeling like a puppet carries a significance that is deeper than what it first appears and can be closely associated with the power of technology. Curiously, puppet, traced back to its classical Latin origins, is derived from the word *pupa*, meaning "girl" (Barnhart, 1988). By a straightforward extension it became the word for doll or puppet as well, which since the sixteenth century, has been used for a particular kind of little doll, one that acts on a stage under human direction. Similarly, the word *pupil*, originally *pupilla*, also derived from *pupa*, was understood to be a person who could see herself reflected in miniature, like a doll, in the eye of the other. The word *pupille,* an orphan child in the care of a guardian, descended from this meaning.

History has informed us that both women and orphans have often been and continue to be perceived as chattle, property of others to be used as cheap and expendable labor, objects in service for instrumental and economic ends. One must ask why it seemed to be such a natural extension for the diminutive of the word *pupa*, which meant "girl", to become the foundation of the word puppet. Does this meaning carry through to nursing, a predominantly female profession that has a strong history of being dominated by others? If some ACNPs experience themselves in this way, they too may see themselves in the eyes of other as miniature, smaller than, and consequently of less significance than those who gaze upon them. From this instrumental and economic viewpoint, it should not be a surprise to discover that, although many ACNPs can acknowledge that "I am a good nurse practitioner," in *being pulled to be more*, they often question themselves – "Am I good enough? Am I doing a good enough job? If I'm not perceived as doing enough of the work, and I'm not doing the CNS role, again am I not good enough?" "So as secure as [ACNPs] can sound in a lot of the stuff, [they] do have a lot of insecurities."

A second trap is the effect of technical language (Bergum, 1996). Labels such as "physician extenders" or "replacements" carry with them not only a sense of "objectness," but also a negative social connotation. Bergum identified that moral language is lost when we engage in this form of discourse. These labels evoke no sense of nurse, the practice of nursing, or the commitment that ACNPs as nurses embody as a result of belonging to the nursing world. As one ACNP expressed about being called a "mini physician" and "physician replacement":

> I think it negates the whole nursing side of it, the whole nursing background piece that we all bring into the nurse practitioner role, and that encompasses all the human compassion aspect that we talked about. It all gets negated. Because when you use the descriptor physician, you're automatically thinking more medical model than, 'oh you take care of families as well as the patients.'

The third trap is the effect of the polarization of self that this view tends to foster. For example, when nursing administrators engage in discourse that dichotomizes the domains of the ACNP role into direct clinical care (i.e., physician replacement activities) and education, leadership, and research (i.e., nursing activities), ACNPs are once again encouraged to experience themselves as being a polarization of opposites.

But who owns the ACNPs? Certainly ACNPs who have found the "perfect fit" in *being an ACNP* reveal that those who hold the purse strings hold the power to determine the expectations for the role. For some, the salary is controlled entirely by nursing, while for others, medicine and nursing hold equal shares.

> I didn't really have a choice because - the other part of my practice I haven't really told you about is - I also do acute brain injury clinic. Last November, I just found it was too much for me to do inpatient ABI, outpatient neurology, plus all the phone calls of neurology, the clinics, and outpatient brain injury clinic. So I gave up the brain injury clinic. And then in

> May, the physicians said that since they pay part of my salary that I needed to go back there. So I'm just struggling a little bit with workload right now.

But as importantly, many ACNPs have also brought to light that they are indebted to the physician(s) with whom they work. Physicians determine both the nature of the safety line with its inherent promise to keep both the patient and the ACNP from harm, plus the nature of the clinical work in which ACNPs are allowed to engage. The degree of autonomy and the scope of their clinical practice are contingent on the physicians with whom they work, for they approve the medical directives (or their equivalent) in the institution and then delegate the type of patients for whom ACNPs may care. Similar to Athena in Homer's *Odyssey* or the Queen of Hearts in Lewis Carroll's *Alice's Adventures in Wonderland*, the physicians give and the physicians withhold or revoke that which ACNPs now hold dear. Some ACNPs are forced to renegotiate their clinical practice each time a change occurs within the medical complement of their clinical service, while a few have even been forced to leave their clinical service when physicians choose to withdraw their support. Besides these factors, a physician may have provided the opportunity for some ACNPs to initiate the ACNP journey, either by lobbying for the ACNP role within their service, or serving as a sponsor that facilitated their entry into the educational programs. Consequently, ACNPs can experience a vulnerability that serves to have a power over them in their clinical practice.

This is the paradoxical nature of power. On the one hand, ACNPs attain the power to belong, to be a certain person, to claim a place with the legitimacy of membership (if only on the margins). On the other hand, ACNPs experience the vulnerability of belonging to, identifying with, and being part of some communities that contribute to defining who they are and thus have a hold on them (Wenger, 1998). The tension between identification and negotiability inherent in power, and its richness and complexity, is thus revealed.

Not all ACNPs experience the tension of *being pulled to be more* in this way. Some experience the *pull*, whether externally or internally motivated, as a call of the Sirens, a welcome opportunity that needs to be seized. The former ACNPs would warn against the allure of this pull, fearing that they will be veered from the role's essential work, ultimately leading to the ACNPs' death. But for the ACNPs who are allured, *being pulled to be more* is more similar to the earlier artistic representations of the two singing sisters; that is, the call is an opportunity to be human birds with wings to fly (Hamilton, 1940/1969). For example, one participant shared how it was her medical mentor who raised the idea that perhaps she should begin to consider her role in "developing nurses professionally." She was both "surprised" that "any physician would ever take the time to use those words" and "embarrassed to say that it took a physician to tell" her to become involved in what she "envisioned to be part of her role." However, she interpreted his remark to mean that she was now competent enough in the clinical management of her patients and therefore "was ready to take on" other challenges. Knowing that she could not engage in additional responsibilities without "protected time," she seized this opportunity to negotiate with both the medical staff and nursing manager for one day per week away from clinical duties. As she noted, although she felt "blessed" to work with such a supportive group, it was her "responsibility to make it happen."

Some ACNPs become restless with the pure clinical nature of their role. The paradoxical nature of their jobs is that the narrowness and tight focus of their specialty, although overwhelming in *Being Adrift*, eventually becomes part of the frustration that they feel. While on the one hand the routine nature of their work brings into being a sense of comfort and confidence, on the other hand, it creates the need and desire for new challenges.

> You know I did find by the end of three or four years that mentally I was starting to get bored because ... as with everything, even reasonably complex patients become routine after a while because you're use to dealing with them and the challenge is to try and find another way to keep yourself mentally stimulated and keep yourself engaged, at least for me. ... [F]or me personally, I need to have something mentally to turn me on, to stimulate me. That's what's fun. So I mean I got some of that doing research. I really enjoyed that because that was a chance to use skills that I hadn't really stretched before and it worked out really well and to see the ripple effects not only on patient care, but on the staff, on the physicians.
>
> And then just sort of as you grow and you get better at things and you get faster at things, then you have a little bit of time to think about all this other stuff and that's sort of when I approached my nursing director and I said, "You know when we set up this job this is what the job description was, this is what it is now, or how it's being practiced, and this is how I see that it needs to be adjusted."

A cue can be taken from those ACNPs who described their restlessness as emerging at the time that their decision-making had become more "honed." It is revealed that not only has their clinical acumen become what the Oxford English Dictionary (Trumble & Stevenson, 2002) describes as clear and precise, fine-edged, sharpened, streamlined and focused, but "honed" can also bring about a "hankering after" something more, as from the old French word, *honger*, meaning to pine for. With the experience of *being comfortable* and *confident* with their *competence* of the clinical management of their patients, many ACNPs begin to re-experience the call to stretch themselves in new and different ways. Feeling a bit bored, less stimulated, or in a bit of a rut, some ACNPs search for new and different opportunities that will help them to *be more challenged*.

> In one sense [clinical practice] can be quite mundane. You know we swab people's noses for MRSA every month [laughs]. That's mundane looking at those results and their iron management because it's part of anemia. And so as I'm doing that month after month after month and they're positive month after month and you've given them the cream to put up their nose month after month, I start to think, "You know I have advanced skill to be doing this job and I'm not sure I'm using it at that point in time." So that's why I like some of the project work and a little bit of the research because then I think I am using some of my advanced skills.

On other hand, some ACNPs are *being pulled to be more* because they believe that it is only in the enactment of the other domains of practice that ACNPs will be viewed as more than physician replacements. Being involved in the other domains of practice holds the possibility of *being more connected* with nurses and *being able to make more of a difference* to the nursing profession. The search for the "perfect fit" for these ACNPs has still not been achieved in *Being an ACNP*.

> I would like to think that we're nurse leaders. I'm not sure that we're so good at that yet. That's something I need to evolve into. Often times when people say we're not just mini physicians, I think well yeah we are you know. And when people say, "Oh what do you do?" "Well I'm like a resident," because that's the most accurate description of my job right now, that is **the** most accurate. So don't be telling me I'm not just a physician replacement because I am. So if that's not what you want, then let's make it more. ...If we spend the majority of our day and majority of our time interacting with physicians and fellows and residents then I think we kind of leave the bedside nurse in the background ...and so I guess we, I, just want to reconnect with nurses more. And I'm not sure what that means or how do it exactly...but there has to be a way to integrate the two better.

As these passages reveal, some ACNPs have a clear sense of direction as to how they should proceed with their journey and as a consequence, *being pulled to be more* is not experienced as a turbulent period. Others may not be so fortunate and struggle to identify where to explore next. All they can acknowledge is the *pull to be more*.

> You know I'd like to have an area or two that I've become very knowledgeable about. I'd like to have some very specific interest or interests that I can work on besides the clinical and whether it's to be able to teach that portion of it or do research on it, I'm not sure. But I'm feeling a need to kind of try and find a focus, something that really interests me. And I do like some of the discharge stuff and maybe I will pursue some of that discharge planning and stuff like that, but I really want something a little bit more concrete too, something maybe not quite physiological but along those lines. So right now it's mostly clinical, but I'm hoping that it'll be a more well rounded role at some point. But I'm floundering; I don't know.

Although ACNPs experience *being more* in *Being an ACNP*, being more in this regard is not quite enough. They begin to experience the need to expand more, to become "rounder," or "more complete." They are ready to tackle more either clinically or in the other components of the advanced practice role. They want to develop and use knowledge and skills they have not heretofore acquired and/or embed into their ACNP practice the knowledge and skills they possess from previous roles. If they encounter resistance to taking on these greater challenges, this *pull to be more* comes into their awareness as a source of tension, which for some merely reveals itself as sources of frustrations that need to be circumnavigated. This tension or struggle comes from external factors that impede their journey to becoming more and finding the "perfect fit."

The major barrier that surfaces to obstruct these ACNPs' attempts to move beyond the clinical domain of their role is lack of administrative and medical support, a finding consistent with other studies that have explored factors that hinder nurse practitioner role performance (Hupcey, 1993; Kleinpell, 1998, Pearson, 1995; Reay et al, 2003). Resistance from physicians presents itself in the form of refusal to grant time away from patient care activities. Nursing management is perceived as silent on the issue, ineffective in lobbying on their behalf, or lacking in an appreciation of the potential for ACNP role development. As one ACNP so poignantly expressed, she found herself constantly "stalled" by the "can't do" philosophy of leadership within her organization. "Physician priorities" and "lack of flexibility with how clinical practice could work" takes precedence over the possibilities for what ACNPs can contribute differently to the organization. These ACNPs struggle with a deep abiding frustration with their inability to negotiate their role description and/or enactment of the role in a way they desire it to be.

> Clinical takes precedence so whenever you're at work you're at the beck and call of the unit. They can call me or page me anytime if there's a shortage of hands and that's where I'm expected to be. Everything else takes second place to clinical. And I just would like some day for it to be more than clinical.

There is a yearning for more that is heightened when they experience glimpses of what this can mean for themselves and others. For example, one ACNP described an opportunity she had had to provide a series of inservices to recovery room nurses who had identified they lacked the knowledge needed to be confident and comfortable with implementing a pharmacological treatment for carcinoid syndrome post embolization. Despite having "to fit it into the middle of a busy day", she "really enjoyed it," knowing that the nurses had a better appreciation of "the whole picture" and could "now safely manage the patients' episodes." She acknowledged that "if she could only do more of that, it would be good for the patients, the staff and herself," but she was unsure if she could get beyond the barriers imposed by the clinical challenges.

Unable to do "what was originally envisioned for the role," another ACNP described her ongoing, albeit occasional, struggle with being a nurse practitioner as "sometimes feeling like being a gopher" for the physicians, "doing their work for them", all the while "hearing the managers say that the ACNPs should be doing research and they should be setting aside time to publish." Unable to accomplish either of the latter in her role, she admitted that sometimes she felt like she had not met the expectations of the role and wished she could do a better job. Under these circumstances, some of these ACNPs engage in other domains of practice on their own time, often working 70-80 hour workweeks, while others search for different employment opportunities or simply live with the tension. As one ACNP shared, she finds the best way to "compromise" and "fit in" some of these other activities is by basically presenting once a year at a yearly conference outside the hospital setting.

> The role is called NP/CNS. So of course what I've described is mostly nurse practitioner stuff and by rights, that's only supposed to take 80% of my time. We're supposed to have 20% or equivalent to one day a week doing the CNS part. Unfortunately there isn't time for that. Management recognizes that they would like us to do more in the CNS part. They're the ones who pay our salary and they're not getting the added nursing value as I've heard some upper management people say. But by the same token the surgeons have become quite accustomed to looking on us as being their assistants so it's hard to explain to them why you're not going to attend to that patient issue because you want to work on something else. So the something else doesn't happen, at least with my role. I just have to sneak it in in other ways. ...It would be nice to be able to wear both hats, but unless I can negotiate one non-clinical day a week, it just won't happen. I'm already working ten hour days. I just can't fit the time in. So I miss out on it.
>
> I feel a bit frustrated that our role is so clinical and it's simply a work load issue. There just isn't time to do the other things. Maybe it's a cop out, I don't know. Maybe someday I'll make time or fight for protected time. But if I were to say okay I want every Friday to be away from the clinical setting then I know that someone else has to pick up the work I do and that will be a burden for them. Plus nobody else knows how to cover my practice.

Lack of support can also come in the form of lack of mentorship opportunities for those domains of practice with which many ACNPs have limited to no knowledge and skill. As a result, these ACNPs re-experience feelings of incompetence, non-confidence, and discomfort with being "an educator, researcher, leader, and/or change agent." They acknowledge that they flounder and shy away from some or all of these activities. Perhaps this is best reflected in the following passage by one ACNP who describes the struggle she lives with regarding meeting her nursing manager's expectation that ACNPs engage in research activities.

> I think it's because our programs, although they have research in them, they don't really; and even subsequent to getting the job and going through your orientation, it isn't on how to do research. It's on how to take care of the patients, and that was where your skill set was developed. ...It's like I need some skill and some guided research because I feel like I don't. Even though I have the theory, it's a whole different ball of wax to implement it, and you know, I believe that one of the reasons that we don't do research is that we don't know that much about research, we're not really skilled in it, and that's why we don't get it off the

> ground and get going. You know if we had somebody who had met with us regularly and helped us develop our ideas, not just say, "Well go off with your idea and come back to me," because it will never get started that way, personally, because you just keep putting those things off. You don't feel skilled in that area, and so you just keep feeling really tentative, and you can't really get going. ...It's not that I'm really adverse to research but I feel like I don't really know what I'm doing.

In fact, in these circumstances, some ACNPs re-experience a number of the feelings associated with *Being Adrift*. Uncertain what they want to do, where they want to go, or how to get there, these ACNPs describe that "being not quite the beginners anymore, but not the experts" is a "frustrating place" to find oneself. As one ACNP acknowledged, when one is a beginner, permission is granted to ask questions and be offered advice. When one is an expert, neither seems to be necessary. Having proven themselves in the clinical arena but not in the other domains of their practice, these ACNPs find themselves without anyone to foster their growth and development and consequently "struggle" to journey beyond this "in-between" place they experience as "middle-grounders."

> They're the experts because they don't have to put so much time and energy into the clinical everyday. You know it doesn't take as much out of them and they have the time and energy to do other things. ...But I find in my experience that ...some of the middle-grounders like me aren't in a position to do that right now. ...We need the office time or protected time off the unit to be able to pursue other things, other interests besides LPs and whatever, because although we're able to do the clinical it still may take us some more time than the experts, plus we don't yet know how to do the other parts of the job. That takes a lot of time too. ...And I think the director tends to lump us together probably more than she should. And although she's very fair, and I'm not really complaining, I think she kind of compares apples and oranges sometimes when maybe she shouldn't, and then if you point that out to her, or if someone points it out to her, "Oh yes you're right," and then it's beginners and experts. Well there's not just beginners and experts, there's the whole in-between.

Even when the *pull to be more* is internally motivated, ACNPs reveal that this pull can be strongly opposed by the pull to stay entirely immersed in the direct clinical practice domain of their role. The allure that advanced clinical management of the patient can have for these nurses, particularly when most of them have been searching to *be more in control*, *more visible*, *more challenged*, *and more connected with patients and families* while performing hands-on care, is not difficult to understand. As one ACNP articulated, the type of focus that results from prescribing, ordering diagnostic tests, and engaging in a more detailed level of physical assessment, "is sexier, more powerful." There is "authoritarian and implied hierarchical power" in the term "physician order," and although this ACNP recognized that this power over is detrimental to nursing, she also readily acknowledged that "when a nurse has that power," it is "very easy to get sucked into it" and to want "to play doctor." This back and forth pull is "a struggle" and requires "a lot of work" not to "give in" to "being seduced by the dark side." This ACNP emphasized that she did not want to imply that medicine is the "bad side." Rather, the point to be appreciated from this *Star Wars* analogy is that the power associated with these entitlements of their role has the ability to lead them away from that which has been intended or envisioned for the role. "Being in a position of the one that people go to get stuff puts the ACNP in a position of power and you can choose to use that to keep yourself up there or you can choose to share it. But it is somewhat of a personal choice."

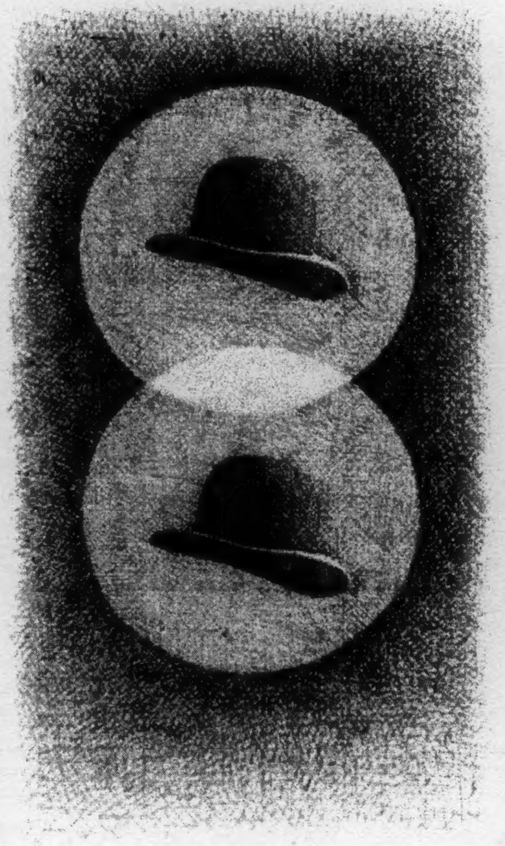
Perhaps this back and forth pull is similar to Frodo's struggle with power, choice, and morality when he becomes the possessor of the Ring of Power in Tolkien's *Lord of the Rings*. Is there a morally right way to use the power one is given? Tolkien suggests that a being who possesses power has little reason to concern him or herself with the dictates of morality. Similarly, the ACNPs' internal struggles with their new power to act beyond traditional nursing limits can force them to reflect on their moral obligations to the nurses with whom they work as well as the nursing profession as a whole. What kind of ACNP should I become is an inherent question buried within this ACNP's analogy. This ACNP's admission of temptation with the "dark side" of power reveals the psychological weight of the power of *Being an ACNP*; there are burdens to be undertaken when they are given the power to act. The desire that some ACNPs have to *be able to make more of a difference* that can come from being a bearer and sharer of power, not a wielder of power, is also revealed. It brings into light how some ACNPs use their power as a matter of conscious choice to escape its constitutive danger.

Living with either/or is promoted when nursing management and others engage in discourse that presents patient care activities as medical functions belonging solely to the ACNP role, while the other domains of practice represent the nursing orientation to the role. ACNPs attempt to manage the ideals of their education and/or expectations that emerge from the discourse of others with the realities of the context of their practice and their own personal desires for the "perfect fit." But how do ACNPs experience their professional self as they live with or journey through the tension experienced in *being pulled to be more*?

Being a Wearer of Two Hats

This time of the ACNPs' journey is once again experienced as a time of living with a polarization of opposites. Perhaps a more accurate reflection is that *being pulled to be* *more* is experienced by ACNPs as *being a wearer of two hats*, a time of living with two identities, that is, wearing the "CNS hat" (education, leadership, research) versus wearing the "NP hat" (direct clinical practice).

> And right now I mostly have my medical or NP hat on but I guess I'd like to be able to do some research and be a principal investigator. ...And I think there's room for expansion in administration as far as being involved in more decision-making as far as nursing within the hospital. ...So I'd like to be able to wear the CNS hat and do a mixture of the nursing role with some of the medical role.
>
> Actually, the CNS/NP title is an interesting one and I like it. The CNS part is more of a clinical nurse educator, as opposed to a clearly CNS position, although there are some things I do as a CNS. So I do really enjoy teaching the nurses on the unit, either informally or in the classroom. When I have the NP hat on, it's basically very physically and psychosocially oriented. ...So I find the CNS hat allows me to have a little bit of time for research, which is something that I wish I could do more of, but I still manage to do a little bit and that's interesting.
>
> NP/CNS is the title here and it's a bit of a misnomer because we're certainly more NP than we are CNS although we keep trying. ...And I'm not sure who came up with the title NP/CNS. The title has gone through many evolutions in this organization. It used to be CNS/NP and then some time over the last 4 or 5 years it switched around. When you look at our job description, I don't even remember the exact proportions, but certain proportions are supposed to be devoted to clinical, education, research, and professional development of the nursing staff.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Time is experienced as being diverted from one role to another; the direct practice activities sacrificed to the other domains of practice, or conversely, the other domains of practice sacrificed at the expense of time spent in direct practice. For some, this polarization results from a resistance to engage in all the various domains of advanced practice when the search for "more" and the "perfect fit" has been personally achieved in *Being an ACNP*. For others, the polarization results from a lack of knowledge or skill in how to perform in these domains, yet all the while the call to find the "perfect fit", to experience more, remains only partially discovered. What's more, this dichotomy is revealed to be even further enhanced by the job title they wear, such as NP, NP/CNS, and CNS/NP. These titles are not designated provincially, regionally or institutionally. In fact, it is not uncommon to find all three titles within one institution. Some ACNPs carry all three titles at different points in their careers as ACNPs, either as a result of a move to another institution and/or a change in expectation for their role within the same institution. But what is the meaning of this polarity for ACNPs? What does it mean in terms of their identity as ACNPs?

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[22] Used with permission by illustrator Tom Phillips and the Folio Society. Becket, S. (2000). *Waiting for Godot* (p. 20). London: The Folio Society.

Titles have the capacity to either constrain or expand what it is ACNPs do. Titles have the power to identify the expectations with regard to the boundaries of their scope of practice and sphere of influence within the role. But therein lay its danger. For example, the singular NP title has the tendency to limit the vision for the ACNP position since the dominant discourse associated with this title recognizes and/or acknowledges only one aspect of the role and speaks to it in terms of medicine. The title eliminates and devalues the other aspects of advanced nursing practice. Somehow the other domains, that is, research, education and leadership/change agent, are either lost or buried within the title, thus making these aspects of the role invisible. It seems that an appreciation for the contributions that NPs can bring to the ACNP role being positioned under the umbrella of advanced nursing practice (CNA, 2002a; CNPI, 2005a) has yet to be translated into the singular NP title at the level where NPs live their work. If then barriers, such as time constraints and lack of resources, also exist to prohibit the expansion of those boundaries, ACNPs are forced to enact the discourse. Enactment of the discourse serves only to reinforce the other's hegemonic view of the role. Only that which is made visible and then is recognized and acknowledged as valuable can become part of the dominant discourse (Heidegger, 1927/1962). Consequently, the title defines the space in which ACNPs live and practice such that a vicious circle and a Catch 22 are created. On the other hand, the titles NP/CNS or CNS/NP suggest that there are two different sets of role functions brought together in such a way as to be carried out by one individual. The specific placement of the two roles within the one title signifies the dominant commitment of ACNPs' time and what is perhaps most valued by the organization and/or the ACNP.

> If we are to look at the role itself, because they put the NP first, that's the big clinical chunk. The academic and the research and the professional development comes as part of the clinical nurse specialist role, and so that takes a much lesser role. So probably 75-80% of our time is clinical and only 25-30% is the CNS hat we put on. Others have a 50-50 split,

> but it doesn't work well when you're by yourself and you have to do all the clinical work. So really I wear the NP hat most of the time.
>
> So the job title is CNS/NP. So the CNS job is really focused on supporting the bedside nurses, educating them, doing conferences. That's the CNS job. The NP job is about 60% of the full time job, although full time is sometimes more than the regular work week. And the NP job is the clinical part. So its really a double job and so the CNS and NP jobs fill a full time job quite well.

Ironically, while some ACNPs lobby to have their title changed from NP to NP/CNS in order to legitimize and/or justify the time they spend or want to spend involved in the other domains of advanced nursing practice, other ACNPs argue that the singular NP title accurately reflects the focus of the role. Although these latter ACNPs are *being pulled to be more* by nursing management, the singular NP title legitimizes their belief that research, education, and leadership/change agent activities belong to CNS practice. If the perfect fit has been found in *Being an ACNP,* the singular title allows them to justify living within the perceived boundaries that this title appears to imply.

Whether the title is NP, NP/CNS, or CNS/NP, each title in its succinctness, its portability, its potential persistence, and its focusing effects, gives ACNPs certain experiences and informs their communities of practice as to what they should pay attention to. In other words, the title becomes a form of reification. But the evocative power of these titles is also double-edged because they do not capture the richness of the lived experiences of ACNPs. Rather, the titles have in some cases appropriated what ACNPs do in very misleading ways. The titles have gained concreteness, which becomes something that both the ACNPs and/or others refer to, strive for, appeal to, and use or misuse in arguments. In fact, the focus for the title(s) may even have become a substitute for what was never intended to be reflected in the first place. Becoming an NP, CNS/NP, or NP/CNS is both the taking on of the label and giving the label specific meanings through participation in practice.

In *being pioneers*, ACNPs have experienced fluidity to their role, which, on the one hand, may have impeded coordination, created apprehension about potential misalignments, and/or resulted in confusion and misunderstandings. On the other hand, this same fluidity has allowed for interactive negotiation, as well as improvisations and creativity. This fluidity permits ACNPs within their communities of practice to seize moments and see opportunities that would not have otherwise been revealed. Titles then can become a form of reification that reinforces or anchors the specificities or expectations of the ACNPs' practice, such as is needed in the former case; but the inherent danger of its power is that too much reliance can be placed on the "anchoring" at the expense of the emergence of all the possibilities for being and becoming ACNPs.

The paradox of the current titling discourse is that it separates the CNS and NP roles, resulting in ACNPs seeing the various domains of practice as a polarity of opposites. Although they may participate in some or all of the domains of practice at this time in their journey, they perceive themselves as performing two jobs. Yet at the same time, the split title legitimizes ACNPs to engage in all the domains when there is external resistance to them doing so, thus opening the possibility for some ACNPs to experience a transformational journey to the unification of practice domains and *Being More*. The allotment of proportions of time, even if only on paper, can also serve to marginalize aspects of the ACNPs' work and/or their desires for more.

ACNPs' stories reveal the relationship between the enactment of the role and their identity as ACNPs as experienced by their title. Some of the ACNPs in *being pulled to be more*, particularly if they have found a fit in *Being an ACNP*, identify themselves more with the dominant focus of the role, which most frequently is associated with the clinical management of the patient. They refer to themselves as NPs and experience a disconnection from the other domains of practice. Although they may participate in other activities, such as education, committee work, or research, these activities are experienced as pieces of the job to be added on to their responsibilities of *Being an ACNP*. These activities are not part of who they are as ACNPs but rather are tasks to be undertaken outside of who they are as ACNPs.

> I think we are nurse practitioners and we may dabble in or do some of the clinical nurse specialist traditional role, but we're predominantly a nurse practitioner.
>
> The titling creates an expectation of who we think we are based on the tasks, rather than how it is and the philosophy with which we come to the job. And I think some of that comes from the way we are viewed by other nurses. It's quite often been viewed or seen that we're physician assistants and we're not fulfilling a nursing role and that's come from administration in the building. And I don't think they have a good understanding of what we do or how we do it, and maybe we haven't presented that well to them either. But they think that in being an NP we're doing more the physician role than the nurse role. There is just a lot of misunderstanding, even in this building, and even though we probably have more nurse practitioners in this building than any other hospital in the country, there is still misunderstanding by administration and nursing administration about what we do and who we are.

"Staying clinically focused and clinically driven" is identified as "the heart of being a nurse practitioner", "otherwise [ACNPs] are not different from the clinical nurse specialist." Yet a tension exists when ACNPs are unable to add or combine "the other pieces of the role" to ensure that they will be "set aside from the clinical assistant type medical model." As a result of these various discourses and the tension perceived, ACNPs can even experience the dichotomy of identifies as "being split" and "straddling two worlds." One ACNP, who carries the title NP/CNS title, shared the struggle she lives with in trying to maintain a nursing identity while wearing the "NP hat." She described her role as "spending 60-70% of [her] time as an acute care nurse practitioner and the other 40-50% of [her] time as really wearing the CNS hat," a time allotment she deemed fair. She related multiple examples of her participation in informal and formal educational initiatives with nursing staff and students, the development and implementation of support programs that focused on the spiritual and sexual needs of her patients within her subspecialty of practice, as well as the initiation and/or participation in research projects prompted by questions arising from her clinical practice. Yet she acknowledged she still "feels schizophrenic."

The following passage from this ACNPs' narrative reveals the ongoing dialectic in which she is engaged and the incredible turmoil that remains unresolved. On the one hand, she recognizes that "the advantage of having the NP hat attached to [her] name" allows her to create opportunities not heretofore afforded. For example, she admitted that the "the NP hat" enabled her to initiate a joint clinic for pediatric patients transitioning to the adult sector within her subspecialty, and the identification of research questions "really came out of wearing [her] NP hat." She acknowledges she "wouldn't want to give up" the ability to manage the patients' symptoms in a timely manner or the procedures where she can "attend to the patients' and families issues and worries in a way that is different from the physicians." On the other hand, she lives with the vulnerability of a fragile safety-line, and works with a team "where everyone is very territorial when it comes to their role" and the members "see [her] only as an assistant to the physician, really just helping out with physical exams and doing procedures." As a result, she "feel[s] like an NP as opposed to a nurse," although she also acknowledges that *Being an ACNP* was "a good fit for more than five years."

> But am I wearing my CNS hat or am I wearing my NP hat now? What is it that I'm doing in all of this? Part of me feels it's more the CNS role, you know. So if I get going with the survivors' program, work with them one-on-one, is that the CNS role or the NP role? You know, I'm just struggling with that right now actually at this point in my career. But in some ways I am always doing the medical piece too. ...And where do I want to go? What do I need to do to feel comfortable going to work every day? ...Maybe I'll be able to really integrate the nursing piece, the CNS piece, with this other piece. I've struggled, no, really gone out of my way to really maintain and develop some skills in terms of research and some other aspects of the CNS role. So I've really tried to wear two hats basically at the same time. But I think I've gotten to the point where I'm not sure that I want to continue in the acute care nurse practitioner piece of it. Or, if I do want to continue, how should it look?

> …So I don't know if it's just me or if other people struggle with this too. Do I need to look at the role a little bit differently and see how I can be happier in that role and how I can really emphasize the nursing piece as opposed to the medical piece?

This ACNP's passage reveals the difficulty of living with the either/or phenomenon and demonstrates the sense of finality that is expected when a choice is eventually made. In other words, when she finally chooses between the ACNP hat and the CNS hat, she holds a belief that the tension with which she has been living will be released; that is, the problem will be solved. However, there is a fallacy in this assumption. The tension experienced by this ACNP and all those ACNPs in *being pulled to be more* is a central tension about the expression of numerous obligations involving a clash of horizons or confrontations of disparate viewpoints. These disparities that have emerged in the different expectations for practice give rise to clashes of intentions, whereby ACNPs, nursing management, physicians, staff nurses, and others, assign motivational aims to the other from their own respective understandings. This contributes to a climate of pre-judgment where one person's or groups' actions are (mis)interpreted from the disparate viewpoint of the other. In this passage, this ACNP is striving to reconcile the disparities from which she cannot escape. Both individual and collective work must be done during this transitional and transformational journey.

Do ACNPs have to choose one or the other hat? Must they live with the tension forever if they choose not to give up either? Perhaps not. Yes, a title and the understanding of what the title means, even a negotiated meaning, is transacted within the "politics" of relationships. ACNPs working within their various communities of practices are not self-contained entities. They grow and develop in larger contexts – historical, social, cultural, and institutional – with specific resources and constraints (Heidegger, 1927/1962; Taylor, 1991; Wenger, 1998). However, geographical proximity to other ACNPs, the network through which information flows, the presence of a job description, and even belonging to a particular organization, are not sufficient to relieve the tension of living with a polarity of opposites. As importantly, the ACNPs' individual responses to their conditions hinder or facilitate the transition through the time of *being pulled to be more*, and *being a wearer of two hats*. As revealed in *Being an ACNP*, ACNPs develop a practice with an inventiveness of their own to do what they are expected to do. Just as ACNPs gradually experience an inner transformation as they journey from *Being adrift* to *Being an ACNP*, some ACNPs are able to embrace the tension created by these two constitutive practices, that is, the CNS hat and the NP hat, and learn the delicate balance of combining both to work toward the larger quest of *Being More*.

The above ACNP's narrative captures the nature and importance of transitional and transformative work, a lesson also taught in the following story as told by Wesorick, Shiparski, Torseth, and Wyngarden (1997). The story begins by explaining how the silkworm, also known as the cecropia moth, was the center of wealth for the Chinese people as early as 2600 B.C. Despite the death penalty for anyone who took the silkworms out of the country, the eggs were taken to other parts of the world. Today, many children in North America take the cocoons from the trees into their homes to watch the miracle of transformation. As one small boy watched the moth struggle to emerge, he thought he could help by opening the cocoon, thus making it easier for the moth to be released. He did not know that the struggle to get out of the cocoon was essential to develop muscle and push blood into the wings. What he thought would help, led to the crippling of the moth. The boy learned at the expense of the cecropia moth that present struggles are essential for future transformation (p. 63).

This is not to say that communities of practice are exempt from creating supportive and nurturing environments that are sensitive to this transitional and transformative process. However, the ACNP needs to continue the journey in order to find a way to reconcile the tension experienced at this time. Some ACNPs use the lived tension of *being a wearer of two hats* in *being pulled to be more* as a call to *Be More*, and so they continue their journey in search of the "perfect fit."

> If I had my choice I would love to be able to able to have time to develop inservices and then do a couple of teaching session on the floor to help keep the nurses current with what's going on with their patients. Then I could satisfy needs of other staff members as well and hopefully indirectly then provide better patient care. And although I mentioned before that research intimidates me because I've never done it, and I'm also not as curious a person I think as a really good researcher is, I would certainly like to work with somebody on their projects and maybe that would open some windows for me. They would be opportunities that I would like to see happen. So I dream and if you don't have a dream you're not going to get anywhere. ...You know, you learn so many things that you tend to go in one way or the other before you really decide what you want to do and who you are. And so I don't think I'm at the end of the road in terms of expanding my role. There's so much more to who I am as an ACNP that has yet to be explored.

CHAPTER EIGHT

BEING MORE

I Dwell in Possibility

I dwell in Possibility –
A fairer House than Prose –
More numerous of Windows –
Superior – for Doors –

Of Chambers as the Cedars –
Impregnable of Eye –
And for an Everlasting Roof
The Gambrels of the Sky –

Of Visitors – the fairest –
For Occupation – This –
The spreading wide my narrow Hands
To gather Paradise –

~ Emily Dickinson (1858/1976)

With new opportunities for learning and an ongoing dialectic engagement, ACNPs may continue their journey through *Being Pulled to Be More* to live the experience of *being more*. *Being more* means that ACNPs undergo another inner transformation, gradually unifying the various domains of the advanced nursing practice role in such a way that increasing the level of participation in any one domain of practice does not dispense with any of the others, but on the contrary, increases the requirements of the others. Why do some ACNPs experience this transformation while others do not?

Wenger (1998) tells the story of two stonecutters who are asked what they are doing. One responds: "I am cutting this stone in a perfectly square shape." The other responds: "I am building a cathedral" (p. 176). As Wenger points out, "both answers are correct and meaningful, but they reflect different relations to the world" (p. 176). The difference between these answers does not imply that one is a better stonecutter than the other, as far as holding the chisel is concerned. At the level of enactment, both may be doing exactly the same thing. But what is suggested is that each of the stonecutter's experience of what they are doing and their sense of self in doing it are different. This difference is a function of imagination.

Perhaps if the ACNP's journey is viewed from the perspective of this analogy, the difference in each of the ACNP's journeys is a function of the imagined vision of the "perfect fit" for which they initiated their respective journeys in the first place. Acknowledging that each journey and way of being is different, not better or worse, each

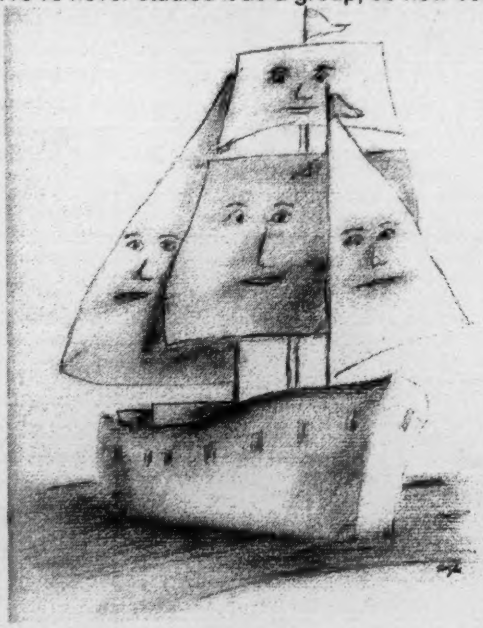
ACNP may learn and understand very different things from the same activities and journey with their ACNP roles to very different places both personally and professionally.

Wenger (1998) viewed the concept of the term imagination in the following way: imagination is "a process of expanding our self by transcending our time and space and creating new images of the world and ourselves" (p. 176). In this sense, imagination is looking at the ACNP role and seeing the possibility of "the perfect fit." Imagination is an ACNP envisioning quality of care for her patients as "one stop care for individuals…that includes health promotion as well as tertiary level care…and being provided outside the walls of a large tertiary care centre because not all clients necessarily like coming to hospitals for their care." Imagination is an ACNP hearing about a health care issue in his or her own setting and knowing that issue is experienced by thousands of patients or nurses around the world and then partnering with other professionals in Morocco, the Caribbean, or Russia in order to find creative solutions through the sharing of expertise. Imagination is envisioning the use of one's artistic talents to establish and research an art therapy program as part of the ACNP role to help ease patients' sufferings. Imagination is seeing oneself as "being able to work with patients and staff all in the same moment."

As evidenced in these illustrations revealed in the ACNPs' stories, the use of the term imagination in this context "emphasizes the creative process of producing new images and of generating new relations through time and space that become constitutive of the self" (Wenger, 1998, p. 177). Imagination involves a different kind of work of the self – one that concerns the production of images of the self and images of the world that transcends or reaches beyond direct engagement. Imagination is not however a purely individual process, but is anchored in social interactions and communal experiences. "It is a mode of belonging that always involves the social world to expand the scope of reality and identity" (p. 178).

> So to be able to be creative with a group of people goes a long way in terms of my feeling happy in my job and growth and satisfaction. And I'm not sure what I mean by being creative. I'm not sure if it's in terms of problem solving or whatever. I mean it's hard to say exactly how it comes through. How do I use my creativity in terms of the NP role? I guess it mainly comes down to identifying areas that need to be looked at. So maybe the fatigue research is a good example, I don't know. I realized that there were patients on cancer treatment who experience a lot of fatigue and families looking to me for advice but I really couldn't offer them advice on how to handle it because there was not anything in the literature on [these types of patients] with cancer experiencing fatigue. So I went to this meeting where I brought up the idea and the nurse researchers and the psychologist in the group understood where I was coming from but the physician group at the table did not understand where I was coming from, or where we were coming from at that point because

> there was a we at that point, that we were going to pursue this topic. Because one of the physicians said, "We've never identified it. We've never studied it as a group, so how could it be important." So maybe just being able to identify issues that are worthwhile looking at and are significant for families that even other people haven't thought of before is about being creative. But interestingly the physicians did come around a few years later, and this one in particular got onto the band wagon around looking at fatigue in our patients with cancer. So I had an opportunity to work with a couple of researchers in Canada and this was at a cross-Canada meeting that I had proposed the idea of looking at fatigue as a potential area of research and they liked the idea. Anyway they are the experienced researchers, so they were the PIs on the project. I became co-investigator on the project and that's fine because that's how you learn, and I obtained a scholarship from the Oncology Nursing Society, a novice researcher mentor award, and [name] was my mentor on the project and I was the novice researcher. So we've done two studies in relation to fatigue with this population. At this point it's gotten to the point where we've developed a brochure on healthy life styles in patients with cancer and I've included a section in there on how you manage fatigue.



As illustrated in this passage, ACNPs' imaginations are fostered by others with imagination. Imagination as anchored in social processes is revealed by ACNPs who discussed the Athenas, Chirons, and John Keatings in their personal and professional lives who were "the wings beneath [their] feet", and by ACNPs who described "the joy", "satisfaction", and the "sense of being empowered" and "enriched" when working in "can do", "why not?", or "open and receptive" environments. Similarly, imagination can be stifled, disconnected, and ineffective, when ACNPs have worked or work with "naysayers," and obstructionists, or practice within "top down" or "follow the rules" environments. Imagining one's practice as a continuing history is also difficult if one lives with the fear of replacement. Conceiving new developments, exploring alternatives, or envisioning possible futures is difficult if one does not have a sense of belonging to one's local community of practice or to the broader social system in which one operates. If ACNPs do not perceive they have power over their own energies or the power to inspire self or others, then imagination can become narrowed and diminished. However, the imagining of who one is, what one can be, and what one can do, as revealed in *being more*, helps deter the ACNP from being only that which has been imagined by others. Perhaps this is best expressed in the following:

> The way in which I create myself is by means of a quest: I go out to the other in order to come back with a self. I "live into" an other's consciousness; I see the world through that other's eyes. But I must never completely meld with that version of things, for the more successfully I do, the more I will fall prey to the limitation of the other's horizon. A complete fusion ... even were it possible, would preclude the difference required by dialogue. (Frank, 2004, citing Clark and Holquist, p. 46).

In *being more*, ACNPs discover how they "really grow again in their understanding" of what nursing practice is and what their practice can be. They even begin to see others in their roles anew and this re-cognition brings about a valuing that was heretofore not present. Perhaps this is what Marcel Proust was referring to when he wrote: "The real act of discovery consists not only in finding new lands, but in seeing with new eyes" (cited in *Bartlett's Familiar Quotations*, 1992, p. 612)

> I had the realization over the first couple of years of being a novice in this role that it doesn't mean that I have control, that I'm the one who does all the speaking, or does all the management. And part of that is the growth process and maturation of being in this new role. It was working with others in a new way I learned about valuing. So for example, I learned more about the respiratory therapists. Who are they and what do they come to the table with? What attributes do they bring to this situation that we're going to work together in? It's sort of that whole re-education about the value of other professions. You know I was so focused before on just our nursing profession and just working within my unit. And so that first experience of working outside that box, I saw that nurses are not the only ones, and that there are different ways of doing things, and that one way is not always the right way, and no one person has control, and you can't have control over everyone else either. It was just to look at how much value we all have and that we all bring what we're experts at to the game, and then we have a much better game ahead of us.

In *being more*, ACNPs continually experience new ways of "building on their nursing practice", "always trying to get to a point to be ready to test new waters," and "set new directions and new horizons." *Being more* is about "trying to imagine how to use all [their] accumulated knowledge and experiences gained through a lifetime of nursing to constantly further this nursing role." *Being more* is about imagining a role that is "not just clinical" but "an advanced practice role that sees clinical nursing in a bigger, broader sense." As one ACNP noted:

> It's fascinating to go back and reflect on where your career path has taken you and the steps you took that you weren't sure where they were going to lead. But in hindsight, you can just see how you can integrate all those skills... And now the NP role gives me the opportunity to integrate so many different aspects into one practice. Now I can bring all the experiences that I've had throughout my career and I think the ACNP role gives me the opportunity to integrate so many different aspects of practice. And it's difficult to integrate all those things because clinical can overwhelm you. But I really truly believe, for me, that

> that is critical. You have to be able to be in a situation where you can work at the bedside, which is the crux of nursing, and refocus on bedside patient care where everything matters. But it's also about being able to bring all of the experiences that I've had throughout my career, being able to work with a variety of people, being able to make a difference at the bedside, and also being able to do some of those other advanced practice roles, being able to go to conferences, present, publish, do research, mentor colleagues, being able to interact with different people, different organizations. I think all of those things are really critical, for me, to the NP role. Because you have to not just make a difference at the bedside, but you have to make a difference to the staff that you work with. I think you need to influence the physicians that you work with, and you need to influence the broader nursing community. Maybe you can't do it all the time with other demands, but at some point you need to be able to say okay I need to put energy into and contribute to moving nursing practice forward. And it's neat because the ACNP role allows me to do everything, has the potential to do everything, if you want to go on that road.

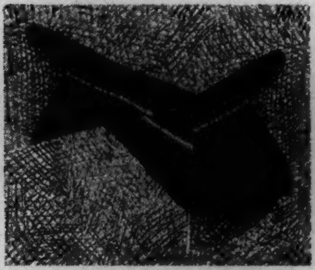
In *being more*, ACNPs reconcile the dichotomy of being NPs and CNSs. As one ACNP noted, they "blend the CNS component with the NP component...to make a true advanced practice role." There is no denying that they struggle to "juggle" or "balance" their time, but time and workload creates the tension, not the sense of being "split." These ACNPs have one identity made up of many components in a mixture that is unique to them, just as other people's identities are unique to them as individuals [even though it is acknowledged that there are similarities associated with Being (Dasein) and being-in-the-world (Heidegger, 1927/1962)].

> So I identify myself as an NP. My title is NP/CNS but I just identify as an NP. But all the other parts of it come along with the role.

Perhaps this reconciliation is most fittingly similar to being Janus, the Roman god of gates, doors, doorways, beginnings, and endings. Janus has been most commonly depicted with two faces looking in opposite directions and has been frequently used to symbolize change and transitions such as the progression of past to future, of one condition to another, of one vision to another, of one world to another, and the growing up of young people (Hamilton, 1940/1969). Hence, Janus has been representative of the middle ground or in-between time and place, returning us once again to Aoki's (1996/2005) image of "crossing" between East and West, a "generative space of possibilities, a space wherein …newness emerges" (p. 318). Perhaps in *being more*, ACNPs find themselves as part of "a story of unfinalized hybridity, of unceasing attempts to bring together disparate parts, respecting their otherness …but believing in a harmony among these parts (Frank, 2004, p. 105). Perhaps in *being more* " there is the recognition of a necessary heterogeneity and diversity; …a conception of "identity" which lives with and through, not despite difference" (Stuart Hall, cited by Frank, p. 104). Perhaps in *being more* through *being an advanced practitioner*, their re-newed "identities are those which are constantly producing and reproducing themselves anew, through transformation and difference" (p. 104).

Being an Advanced Practitioner

The following are three ACNPs' stories. Although these passages are lengthier than what has generally been offered heretofore, the participants' own words are used to bring forth the uniqueness of their practices and the work in which they are engaged based on their imagination of what it means to *be an advanced practitioner* and thus who they are as ACNPs. Their stories reveal that what they choose to tell about the nature of being ACNPs is as important as what they say.



[23] The first story concerns a nurse who has been an ACNP working in a critical care environment. Her designated title is NP and, despite numerous battles, such as unemployment, workload demands, bedside nursing resistance, and lack of administrative support, she believes she has finally found the "perfect fit" in *being more*. For her, an NP is "part of that big umbrella of advanced practice nursing" where "[CNSs and NPs] need to work together because [they both] have essentially the same job description, it just varies in how much of what you do."

> Now the clinical component of my job is supposed to be 75% of my role. In reality it's probably more 99% of my job and part of the difficulty is that nobody knows that there's another 25% of my job, even though I keep telling them over and over again. But my role involves research and so I have collaborated with one of the CNSs and we've done several research projects and published and presented at conferences. We try to encourage that kind of stuff, and it's very unusual if we don't present at least once every year at a national or international conference. Together we identify day-to-day issues that frustrate us or that we need to improve on or that we see are problems and have global effects on the whole program. So for example, this early extubation thing came about because we could see that there were gaps in the system where patients were not being extubated when they should, which was increasing their ICU time, which was increasing their incidence of ventilator associated pneumonia, which was increasing their length of stay, and so on. And by improving our practice in one simple thing, we could change not every thing, but we could prevent a lot of complications for patients, and have improved outcomes, and decrease length of stay, and save money, and all those things that everybody wants to hear. So together- because as an NP I don't have a zillion hours to develop proposals and go to ethics - so we worked together. We both did the lit review, but she would get stuff together on paper, and then we would work these projects through, and we went to ethics, and I approached nurses in the area to help us out with data collection and stuff just to try to bring them into thinking about nursing research, and getting excited about it maybe, and wanting to be part of improving stuff. And we found a number of

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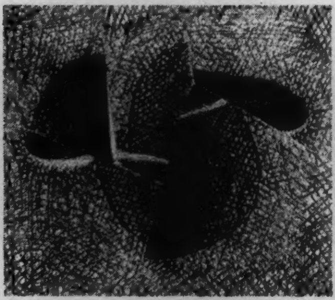
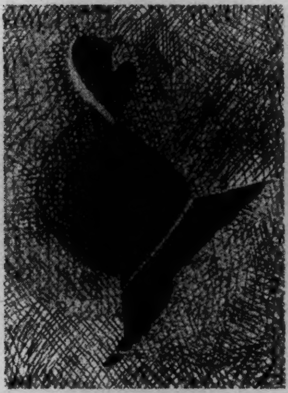
[23] The three pictures presented are used with permission by illustrator Tom Phillips and the Folio Society. Becket, S. (2000). *Waiting for Godot* (p. 93). London: The Folio Society.

> really easily resolvable reasons why patients weren't being extubated early, such as keeping their sedation on so that the nurses could have coffee break, or no respiratory therapist around because they're all on lunch break, or no residents around to give them an extubation order. And so we educated all the staff on the benefits of early extubation that brought out what the research says we should be doing to improve patient outcomes and patient comfort for that matter. I mean people have no idea how bad it feels to have an ET tube right, and I don't either, but when you read and you talk to people and they say the worst thing ever is that tube in their throat, then why would you keep in any longer than you absolutely have to. It interrupts the patient communication patterns; it causes pain; it causes coughing which obviously causes pain when you have a chest incision; and just their overall sense of well being is worse when they're intubated; and their interactions with their families. So then we did a post evaluation and we have improved significantly in getting these patients extubated earlier and so that's a positive thing. So one thing that we could say to the administration is that the cost of the major drug that we used for sedation was decreased by half; so that's significant, when it goes from thirty thousand dollars to fifteen thousand dollars for one drug. And then now we're involved in updating our pain assessment and documentation and changing all of that. So I was involved in education with that. And we've also just written two more proposals for two more studies on ventilator associated pneumonia and oral care, and one on diabetic management. And I'm also on a quality assurance committee for the practices of insulin and diabetic management for the hospital. And I think the nursing staff sees me as a role model and maybe I've even been a mentor to a few nurses because we have had probably about 10 nurses in our ICU actually go back into the Masters program because they actually want to do this role. And they see me as somebody who has some knowledge that they can approach to ask questions or who they see as being able to facilitate their learning as well. I love to do one-on-one teaching at the bedside with them, and a lot to times it happens when things are happening with their patients and they're getting orders for this and that and sometimes when they are new or less experienced, they don't always feel comfortable asking physicians because they're scared or it's a power thing, but they feel comfortable saying to me, "Well why exactly are we doing this, what is the reason and what is the outcome hopefully going to be?" So it makes you feel good about yourself as a nurse and as a person to be able to do all these things, as well as have hands on all the time.



The second story involves a NP who became tired of being told by senior nursing administration that she "could not have or do everything" in nursing. She needed "to make up her mind" as to whether she wanted to be a clinician, a researcher, an educator, or a manager. Having "wrestled and wrestled' with the question, "What do you want to do?" she finally decided that she was" just going to have it all"; she was going "to do everything." In her clinical role as a gerontology NP she is able to generate questions about practice that she then takes through the research process. The research findings are subsequently used to implement changes thereby improving the quality of patient care. Her clinical and academic teaching opportunities also allow her to continually share with and learn from others. *Being an advanced practitioner* for this ACNP means "doing everything," all the while being able to make "more of a difference one patient at a time." This is but a small piece of a passage she shared on why she believes she "has it all" as an ACNP, a role she describes as an advanced practice nursing role.

> In my NP role on the consultation service, I get to go all over the hospital – emergency, ortho, etc. and so it's really broadened my base. And we've done some really fun work - actually the ortho service has really gotten on board with us. And we've done a lot of teaching with ortho and they've invited us back several times, so I guess they like us [laughs]. So we try really hard not to be the people that come and say, "Oh we're from geriatrics and we know all about care for older people, and we're going to tell you all the bad things that you do." So we really try to present it as a partnership with them because they know all about orthopedics and we know squat about orthopedics, but we know about some of the issues that are happening and the de-conditioning issues and these medication issues and all of those things with the patients, so we're just trying to help put this together. And we've had so much fun. We always get a great reception from them. And again I can't take credit for all of this because I have this really great pharmacy teaching partner. Although we've been colleagues for a long time, we got to start building our relationship in a different way when I changed my role. And our usage of some of the medications that are less senior friendly is down on ortho. When I screen the consults on ortho now, I'm not sitting there taking off Tylenol #3 and discontinuing Gravol and doing all those things any more. Like those drugs are gone. And so I get to effect patient care in that way too. Now the ortho nursing manager and I are going to work together to go through the computerized medication records and do a comparison between our teaching periods about uses of targeted drugs and then do a cost analysis of the changes. And then as a nurse practitioner when I'm doing consults, they'll ask me questions, whether it's the nurses on the team or the social workers on discharge planning. Next I'm going to work with some nurses and maybe some students on a little research project about Foley catheters because of all the nosocomial infections in seniors and it's just not normal to pee through a catheter and so let's just get them out. You know, when I first started as an NP we really wanted our team to try and develop a geriatric assessment form that was more interdisciplinary so that I wasn't going and doing a cognitive assessment and the occupational therapist was going and doing the same cognitive assessment. And we wanted to make it with the understanding that it could be any of the team members contributing to that. So we worked on this and now we've taken it regionally and we're going to standardize it so that we are not repeating work across institutions and we're helping to build trust in each other as colleagues. And we also made a conscious choice to generate a problem list rather than the diagnosis list, which helps us to focus on the patient and their issues, and let's all the health care professionals create or add to the list. And now we need to work on the discharge planning based on the patient centered list.



The third story is shared by an ACNP with the designated job title of NP/CNS who worked within a cardiology program. *Being more* for this ACNP is about "the ability to influence change on many levels," by being actively involved in all the domains of practice of the advanced nursing practice role. The ACNP role as experienced as *being an advanced practitioner*, offers her "the chance to do everything." As a result, "there's always new things to learn" with "new challenges" "to mentally turn [her] on, to stimulate [her]." She is "constantly stretched," but then "sees the ripple effects, not only on patient care, but on the nursing staff, and even on the physicians." *Being more* is about "the whole package of advanced practice" and as such, is "just the perfect nursing role."

> I honestly believe that most nurses have the knowledge to do a lot of the stuff that NPs do. They can do a lot of things physicians do, but what prevents them is that the structure just doesn't allow them to practice to that level. So in many senses, I see the NP role as being a first step to expanding the role of the staff nurse. I think there's a lot of potential, like for example, to use the sheath example, only physicians did it when I first arrived. Then I took it on, and now the staff nurses do it. And there was an evolution to it. I mean among the nursing staff that I worked with there was a large core of very experienced, very expert nurses. And they expressed interest in doing it, learning how to do it, although there's always an issue because their workloads are heavy. I was doing a research study looking at getting people out of bed earlier, after they had their sheaths pulled, because when I first arrived they were flat for six hours, couldn't get out of bed for six hours. But homeostasis at the site usually takes half an hour to forty-five minutes; so from that point on it would be six hours before they could get out of bed. I felt that that was too long. We should be able to get them out at two. So we did a randomized control trial, randomizing people to six hours, four hours and two hours and then looking at all the vascular complications. But one of the things that we needed to hold constant was the quality of the person doing the sheath removal because that can determine some complication rates. So if we had people training or learning how to do it that was going to mess the data. So they agreed to wait until data collection was complete and then we would look at moving to having select members of staff nurses do it. ...And you know, I had physicians whose only conception of a nurse in research was the people that helped them with their research. Most of them in the group had never heard of a nurse being a principal investigator on a research study and actually conducting independent research. This was a totally new concept to them. But they were tremendous. I mean when I presented my research findings and every cardiologist in the department took time out of their schedule to come to my presentation and they all asked questions. And there were staff nurses there that came in on their day off. And we had decided ahead of time, before I'd even started doing the research, I said, "I'm not going to go through all this as a paper exercise." I said, "If this shows that it's safe to reduce bed rest, then we need to implement the change." And we all agreed as an advisory group that we would implement that change. And I did that up front. And so we met and the day after I presented it, the change of practice went into effect. They went from six hours to two hours, which is really cool. And then that was better for the patient and that decreased the workload for the nurses. ...So after that the staff nurses were even more interested in removing the sheaths and I think seeing me do it made it easier for them to say, "Well if she can do it, I can do it too;" and they did. Occasionally they'd pull the sheath and the groin clamp would come off and then they'd re-bleed later. The experienced nurses would always put the groin clamp on and then call me and I'd come and say, "Oh it's fine. You've done a great job. Just carry on." Because they can manage it. They're fine doing that. ...And, you know, I presented at the Canadian Cardiovascular Society conference, which is a medical and nursing international conference. I had submitted two papers to the medical side and two to the nursing side and that was specific because the dynamic is, if the physicians don't buy it, it doesn't matter what the nurses say. If the physicians aren't convinced that it's going to be safe then practice isn't going to change. And so I had two very stats-related, safety-driven presentations in the medical part and then two more patient-focused ones in the nursing. What was even neater was that my colleagues in Toronto and Vancouver also changed their practice following that presentation because their physicians were there. So I mean the neat thing was not only changing practice on our unit but changing practice well outside that. And I think for a lot of physicians just the realization that a nurse can do clinically relevant research that changes practice in a positive way was something completely new to most of them. And it was wonderful to see the ripple effects of that on the staff. After that, when I was being introduced to the new staff on the floor by the senior staff, they introduced me as "This is our nurse practitioner. She's the one who's responsible for all the bedrest research." So it was the research that

> they were focusing on. One staff member sought me out at a professional nursing meeting and said, "I've heard all about your research and I'd really love to work with you on nursing research." And he said nursing research. But when they can see that there's a usefulness; that they can actually use this stuff, and they can be involved in it, and it's great to see them turned on.

What is illuminated through these three stories? What is shared outright and what is found between the lines? It is revealed that *being more* in *being advanced practitioners* is what gives meaning to the ACNPs' practice; it is also revealed how their sense of identity has been re-newed. In other words, these stories illuminate the transformation to *being more* as experienced in *being an advanced practitioner.* During this time of *being an advanced practitioner*, all domains of practice are viewed as inseparable and mutually constitutive, and whose complementarity gives the ACNP role its richness, dynamism, and individual uniqueness. Ultimately, the unification becomes how ACNPs identify themselves and how they are seen by others in their communities of practice.

This search to be more through *being an advanced practitioner* is associated with a personal moral imperative. The sharing of power and using power to strengthen others is revealed as a constitutive element of *being an advanced practitioner.* In addition to these three passages, ACNPs demonstrate this vividly when they make a public demonstration of recognition for the other's perspective, thus validating, honoring, and valuing their knowledge and skills. They challenge the power-over perspective by asking, "Why would you not include those who have the knowledge and skills? Why would you not hold those who do the job accountable for looking for the gaps, identifying redundancies, and knowing how to find the solutions? Why is there a need to tell bright people what to do? Why do we not work together to solve problems?" They know their own limits – "I am not super-duper"; "I am not a super nurse, because again that's not being respectful of my nursing colleagues. We are all there to provide patient care and we all bring something vital and important to the care of the patient" - but imagine the possibilities in others. In this way, they identify themselves as nurses without any extraordinary power and work hard to help others find the power within. As a result, paradoxically, their own power is amplified, as is their own sense of the possible.

Driven by a desire to always *be more challenged* and *more connected* with the nursing profession, *being advanced practitioners* means ACNPs continuously expand their communities of practice through multiple and varied partnerships. They strive to make *more visible* for nursing and others that which has heretofore been invisible in nursing. They work hard to involve others, particularly staff nurses, in every element of what they do. At this point in the ACNPs' journey, "having the chance to be pioneers" means they can "lead the process of creating a vision that nobody really knows what it is going to look like in the end", "the diversity of which is limited only by one's own imagination." In other words, *being an advanced practitioner* enables the ACNPs' to achieve levels of scale and complexity that gives new dimensions to their belonging. Just as the etymology of the word *pioneer* implies, the ACNPs unearth the rich stores and abundant sources of rewards inherent in *being an advanced practitioner* and as a consequence they experience *being more*. In *being more*, they discover "the perfect fit" for which they have been searching. The ACNPs find a greater sense of personal fulfillment as nurses through their opportunities to make more of a diverse and broader difference to their patients, families, and the nursing profession and they discover more of their own possibilities for being who they desire to be.

These three stories reveal that in *being an advanced practitioner*, ACNPs' work is more than participation in each of the domains of practice. Their work is one of engagement in building and nurturing communities of practice that have the patient and families as the core focus. But, it is conducted through the development of partnerships that foster the growth and development of others, particularly nursing (but not only nursing), in order that the best delivery of care will be possible. As such, the three ACNPs' stories reveal their community-building conversations and the negotiation of new situations through partnerships in projects, research, and teaching centered on patient care issues. Through their ongoing development of interpersonal relationships, ACNPs pursue common enterprises in concert with nurses, physicians, dietitians, pharmacists, social workers, and others. As a result of engaging in shared activities, they create a history of shared experiences. Their efforts build and expand the level of competence within their communities of practice through these interacting trajectories. Consequently, the ACNPs' identities and those of others are continually being shaped in relationship to one another. In *being an advanced practitioner*, ACNPs expand the boundaries of nursing and open the peripheries to allow for engagement with all those who work within these communities.

These stories also reveal that ACNPs' imaginations come from a place of stepping back and looking at their engagement "through the eyes of an outsider" (Wenger, 1998, p. 185). By reflecting on the Others' experiences, they imagine the possibilities in the situation and in Others; they see themselves in new ways, and imagine the "multiple constellations" (p. 185) that could be the contexts for their practices. They explore other ways of doing what they do, take risks, and create unlikely connections. In fact, ACNPs in *being advanced practitioners* reveal that there is some degree of "playfulness" (p. 185) to the way they engage in their work. As several ACNPs shared, they are having "fun" in discovering *being more*. Moreover, they are able to make visible what it is they do through their day-to-day sharing of their stories and explanations with others. By involving others in the doing of research, project work, writing, presenting, and problem-solving, others too begin to imagine "the present as only one of many possibilities and the future as a number of possibilities" (p. 185).

Perhaps what happens in *being an advanced practitioner* is that as a result of reaching out to their colleagues in understanding, ACNPs begin to feel understood (Dickson, 1991). Through an attentive reverence of nurturing engagements with their communities of practice, an opening is created where ACNPs emerge with the perception of being transformed. As noted by Nichols' (2005) there is a strong connection between "attentive reverence of nurturing engagements" and "feeling understood" and hence our sense of belonging and sense of self are strengthened.

> If listening strengthens our relationships by cementing our connection with another, it also fortifies our sense of self. In the presence of a receptive listener, we're able to clarify what we think and discover what we feel. Thus, in giving an account of our experience to someone who listens, we are better able to listen to ourselves. Our lives are co-authored in dialogue. (p. 10)

Conceivably this way of engaging may be similar to what Reay, Golden-Biddle, and GermAnn (2006) have referred to as cultivating opportunities grounded in ACNPs' embeddedness. While embeddedness serves to constrain some ACNPs, they revealed through their research how it can also facilitate action because it serves as a "means of stratification by opening windows of opportunity" (Dacin, Ventresca, & Beal, 1999, p. 335). ACNPs use their embeddedness or engagement with others in their community of practice as a source of opportunity "to evaluate the potential success of specific strategies and choose particular times and places to act" (Reay et al., p. 979). In *being advanced practitioners*, ACNPs continue to develop and apply their deep knowledge of the system and its actors to select and frame arguments for making changes within clinical practice. They use their knowledge and understanding of their communities to recognize and take advantage of opportunities.

As evidenced in the three stories, as well as in Reay et al.'s (2006) work, ACNPs begin to gradually and subtly remove system barriers and prove the value of the ACNP role in richer and deeper ways. In *being advanced practitioners*, they find they can *make more of a difference* and “secure small wins” (p. 990) working at the front line day-by-day and interaction-by-interaction. Gradually they are seen by others as *being more*. Paradoxically, in finding ways to fit the ACNP role into already established systems and structures, they also change the system to accommodate this new role and in doing so find “the perfect fit” for themselves. Once they create and strengthen their connections in new ways, they begin to recognize that the ACNP role would be relatively difficult to disconnect or eliminate.

> Administration sees the ripple effect on patient care, the staff, and even the physicians. I mean some practices have changed for the better because of the research we do on questions that arise from our own practice. Nurses feel better informed. We hear that the patients are happy with the care with provide. I think they know that they would lose a great deal if they got rid of this role now.

These stories illuminate a life in a process of a multiplicity of assemblages, of connections, and of interactions. In *being advanced practitioners*, ACNPs' lives are not attached to an official structure, a rigid pattern, or an imposed or straightforward stream of thought. In *being an advanced practitioner*, they engage in what perhaps could be thought of as “rhizomatic thought” (Holmes & Gastaldo, 2004), a process that perhaps is fostered in *being pioneers*; that is, their lives emerge and grow in simultaneous, multiple ways, without a beginning or an ending and in a constant state of play (p. 261). In this way, they become capable of promoting the creation of new concepts that allow for the emergence of alternative possibilities for self, for others, and for nursing. In *being an advanced practitioner*, they demonstrate abilities to tolerate ambiguity and chaos. They do not rely on certitudes to progress or develop new ways of being for self or for nursing. Their imaginations allow them to continuously ‘become other’ and they are willing to take the risk and the challenges that are associated with the metamorphosis. In this way of living their work, they discover *being more* and find the “perfect fit.”

CHAPTER NINE
AN EPILOGUE TO THE UNCOVERING OF THE ACNPS' JOURNEY

> It is not easy to be a pioneer – but oh, it is fascinating! I would not trade one moment, even the worst moment, for all the riches in the world.
> ~ Elizabeth Blackwell (as cited by Grant & Carter, 2004, p.11)

How does one end that which is only the beginning? This interpretive inquiry reveals the meaning in ACNPs' lived experiences of being an ACNP. Through deepening our understanding of the nature of their nursing practice, this work serves to make visible aspects of the ACNP role as lived that have heretofore been invisible. Without visibility, this way of knowing and understanding ACNPs cannot find a voice in professional and social discourse.

This work has revealed that the ACNP's transformational journey reflects an attempt to create a context in which to proceed with their professional lives. The journey involves, among other things, *being competent*, *confident*, and *comfortable* with the clinical management of their patients, having fun, doing well, feeling good about what they are able to accomplish and how it is accomplished, dealing with boredom, thinking about the future, and struggling to maintain a sense of self they can live with. The ACNPs' transformational journey is about finding "the perfect fit," the experience of which occurs through their mutual engagement in practice. In this sense, the ACNP's journey is about navigating a way into the future, but it also involves being called to draw on the past.

At this time in Canadian nursing history, the nature of being an ACNP is as much about writing a history as it is about drawing a map. Yet paradoxically, in some respects this must be an uncharted journey, for the lived experience of being an ACNP takes its own shape for each person. It is not as if nurses who choose to become ACNPs all set sail from port A and then reach a fixed destination via a predetermined route within a designated timeframe. The nature of their journeys comes into existence moment by moment as it is lived within their community of practice. ACNPs' daily practice, with its mixture of submission and assertion, is a complex, collectively negotiated response to what they understand to be their situation (Wenger, 1988, p. 78). Their journey is not reducible to a single element such as power, satisfaction, competition, collaboration, desire, or economic relations. As Wenger discovered in his work on communities of practice, how ACNPs go about doing their work and who they are is a complex mixture of power and dependence, expertise and helplessness, success and failure, alliance and competition, ease and struggle, authority and collegiality, resistance and compliance, fun and boredom, trust and suspicion.

As ACNPs undergo their journey, it has been revealed that there is a shift in the relationships within each community of practice. This shift occurs in a subtle and complex fashion. Yet all the while, the change gradually uncovers the differences between the ACNP role and the nursing and medical roles to which they are similar. Every newly constructed difference in how work is conducted as a result of the ACNP's presence, every new negotiation between physician and ACNP or bedside nurse and ACNP, as well as every new merger of work activities brought from the nursing and medical worlds, brings about both a change in the ecology of the communities of practice and the ACNP's sense of self in this role. As a result, ACNPs begin to see themselves a-new and gradually undergo an inner transformation. In addition, others, particularly nurses, have the opportunity to see nursing in a new way, as well as new possibilities for being.

The intent of the question that guided this work was to allow the phenomenon to show itself. The paradoxical nature of hermeneutic phenomenological inquiry is that while there is a deeper and richer understanding of the question, something of itself must be held in reserve. The very thing that aims to uncover what is hiding, is that which restricts it (Moules, 2002). Instead, the power of this work is found in its ability to have the question live on, seeking never to be complete, just more deeply and richly understood. The aim was to describe and find possible meaning in the ACNPs' lived experience. To that end, the intended aim has been accomplished. However, as Moules elucidates, this inquiry is a "work in progress," and thus in the truest sense remains unfinished.

However, this understanding does not mean that there is not a response to the recognition that occurs when something rings "true" of what is said in the particular. van Manen (2002b) purported, understanding in the phenomenological sense has the potential to sponsor more "thoughtful action: action full of thought and thought full of action" (p. 88). In other words, possibilities for different ways of understanding and being with ACNPs in education, practice, or research, are planted and cultivated as a result of the bringing forth of something new and/or re-cognizing that which has been taken-for-granted. For example, new thoughts concerning how ACNPs are assigned various titles and the influence the title can have on the enactment and meaning of the role for the ACNP and others may evoke discussion at the local and national level. Similarly, having humanized the ACNPs' lived experience as a transformational journey may sensitize educators and local administrators to question what strategies best meet the various and changing needs of ACNPs through this transitional process. Local administrators may question what supports are offered to the ACNPs in their institutions in terms of mentorship, not only in the clinical management of patients, but also in terms of the development of the research, leadership, and education acumen of individuals in the ACNP role. They may begin to engage in ongoing and more intimate dialogue with ACNPs about what the "perfect fit" looks like for each of them.

The visibility of the ways in which ACNPs make a difference embedded in a moral imperative of "caring" as integrated with some of the traditional medical "curing" activities raises questions concerning the structure of their practices. If the "additional" time spent with patients and their families is more conducive to holistic care, which is ultimately more healing for patients and satisfying for ACNPs, should their practices be restructured in such a way that time is afforded them to do so? At the very least, the possibility of ACNPs to transcend the binary opposition of care and cure, thus opening a new space for being, as has been revealed by ACNPs, should evoke the nursing profession to pause and reconsider the discourse that has asked "Whither the nurse in nurse practitioner?" and has suggested the answer to the question "To be or not to be?" is the latter.

Explication of the nature of the ACNP journey also calls into question the tendency to underestimate the complexities of taking on this role. All of us (e.g., educators, administrators, nurses at the bedside, physicians) need to recognize and acknowledge the profound effect the transformational journey has on ACNPs. We also need to recognize and acknowledge that their journey does not end with the attainment of competence, confidence, and comfort in the clinical domain of practice. To dismiss this knowledge is to underestimate the power their experience has upon their identity, their sense of belonging, and how they embody their practice. *Being disconnected*, *being uncertain*, and *being lost*, for example, have been experiences held in secrecy by ACNPs, in the assumption that they are a problem particular to the individual. How many ACNPs have left (or could leave) this role as a result of misunderstanding that these feelings are theirs alone? How can we use this information to lessen their feelings of isolation and help ACNPs engage in a dialectic that will enhance the transformation from *being adrift* to *being ACNPs*?

Answers to such questions as - Has anyone else felt like this? What is happening to me? Is this normal? How will I know when I am good enough? – do not lie in the findings from this study. On the contrary, every ACNP must undertake and learn from their own journey. Nevertheless, the ACNPs' transformational journey as revealed here is important, as it is a place from which they can perceive and understand their own experience. Opening up a dialogue with an openness to who they are and who they want to be, with an appreciation of the journey, can promote self discovery and development of the imagination.

The question - How does one end that which is only the beginning? – is put forth again for consideration. "A man went to knock at the king's door and said, 'Give me a boat'" (p. 1). So begins José Saramago's (1998/1999) simple, but intriguing short story entitled *The Tale of the Unknown Island*, a fable that succinctly but carefully conveys the story of ACNPs' transformational journey. An unnamed man arrives at the king's "door for petitions," a door the king neglects because he waits by the "door for favors" (favors being offered to the king). The man's tenacity happily coincides with the king's fear of a popular revolt, which results in the sovereign begrudgingly granting the man a seaworthy boat with which he can sail to find "the unknown island." In the ensuing philosophical discussion about whether such an island exists or is findable, it is revealed that the unknown man is a dreamer, with bold imagination and strong will. When the king assures him that all the islands have already been discovered, the man refuses to believe it, explaining that man exists "simply because there can't possibly not be an unknown island" (p. 12). Having overheard the entire conversation, the palace cleaning woman leaves the royal residence to join the man on his voyage of discovery. The two would-be explorers claim the boat, only to realize they have no provisions, map, or crew. Whether the vessel, newly christened The Unknown Island, ever finds its destination remains a mystery, but several crucial lessons endure: (1) Follow your dream and your dream will follow you; (2) If you don't step outside yourself, you'll never discover who you are; and (3) When sailing, there are more teachers along the way than you can ever expect or predict.

Some ACNPs find "the perfect fit" for which they were searching when they initiated their journey in *being ACNPs*. However, in *being ACNPs*, they continue to live with the tension of *being pulled to be more*. It is unknown if the tensions they experience will ever become the call to continue their journey. Returning to *Moby-Dick*, remember what Melville's story is attempting to tell us. New Bedford, at best, is a point of departure, not a final destination and only exists in relation to the journey out. As such, the journey out constitutes New Bedford as a temporary resting point, a way station, from which one begins another journey. Melville calls on us to live "landless" and "shoreless," to continuously journey out from safe harbors upon a voyage that is open, and for which there can be no final destination or end point. There are some ACNPs who continuously answer this call and are constantly challenging themselves to think nursing and health care delivery in new ways, to leave the comfort and safety of what they think they know to be true about both, to imagine what could be, and to act and relate in new ways. It remains a mystery at this point where they will journey from here, but their journey is not over, because for ACNPs who live the experience of *being more*, *being more* is about the constant search for more. Some already imagine furthering their education in order to bring more knowledge and ideas to their practice, while others imagine a nursing practice that is more global. Perhaps for ACNPs who experience *being more*, their lived experience is as Geena Davis (as cited by Morris, 1999) opined:

> I view life as a journey. It's not so much having some goal and getting to it. It's taking the journey itself that matters ... I don't think life is about arriving somewhere and then just hanging out. It's expanding and expanding and trying and trying to get somewhere new and never stopping. It's getting out your colors and showing them. (p. 320)

…that one most perilous and long voyage ended, only begins a second; and a second ended, only begins a third ...

~ Herman Melville (1851/1992), *Moby Dick*, p. 66

Both the End and the Beginning

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APPENDIX A
RECRUITMENT LETTER

Research Title: The Experience of Being an Acute Care Nurse Practitioner

My name is Judy Rashotte and I am a doctoral candidate at the University of Alberta, Faculty of Nursing, conducting research that explores the nature of being an acute care nurse practitioner (AC-NP). The stories you share with me through an interview process will help to provide a deeper understanding of what it means to be a NP as lived in the acute care setting and your unique ability and situation to contribute to nursing practice and patient care. I am interested in your personal journey, including your experiences of deciding and learning to be a NP as well as meaningful events and relationships you recall related to your NP practice. It is sincerely hoped that the findings from this study will help improve the NP educational programs and their integration into the practice setting.

You will be asked to participate in one or more face-to-face interviews with me. The first interview is expected to last 1-2 hours depending on your comfort and energy level. If you agree to continue to be involved, a second interview of similar length may be held to continue the exploration of your experience of being an AC-NP. A third follow-up interview may be scheduled to ensure that I understand the information you have shared with me or I may ask you to read and discuss a draft of the chapters of my dissertation that describe the meanings found. This follow-up discussion may be conducted by telephone and should take approximately one hour or less. The interviews will be arranged at a time and place that is convenient for you. All interviews will be audio-recorded.

Although there is no compensation for your participation in this study, you will have the opportunity to reflect on your experiences in as much depth as you choose. Some individuals find that talking about their experience helps them to gain perspective on what has happened in the past, which potentially enables new insights and options to emerge. Should you decide to participate, you will also be contributing to the development of knowledge that may help nursing, other health care professionals (e.g., physicians, health care administrators) and the public at large gain greater understanding into what it means to be a NP and a nurse. In addition to your time commitment, the only risk to you may be a feeling of personal vulnerability associated with the information you choose to share.

Confidentiality will be respected at all times. A code number will be used to identify you on the transcripts. I will erase your name and any other identifying information from the tapes. It is intended that the information and findings of this study be published and presented at conferences, but again, any identifying information will not be used. Should you not want specific passages from your interviews quoted, you would only need to inform me at the end of the interview. The interview tapes will be kept in a locked file at my home and will be destroyed after the study is completed. If you are agreeable, a copy of the original transcripts will be kept for possible future analysis that may result from ongoing studies related to the nature of being a NP. Only I will have access to all research material. Although I will not obtain further consent from you, appropriate approval will be sought from an ethical review committee prior to beginning any study involving your interview data.

Participation in this study is entirely voluntary. You will be free to withdraw from the study at any time and it will not affect your employment. You will simply need to inform me of your decision. You will not have to answer any questions or discuss any subject in the interview if you do not want to. You will be free to stop the interview at any time if you wish. Should you decide at any time during the study that you want to delete any information you shared with me, that information will be immediately withdrawn and destroyed. I will respect your choices without question. Your continued participation should be as informed as your initial consent, so I will also encourage you to bring up any concerns or questions you may have during the interviews or course of the study so that we can discuss them.

If you are interested in participating in this study, please contact me through one of the following venues:

Judy Rashotte, RN, MScN
Phone: (613)- 526-1651 (Call collect)
E-Mail: bjpjtigger@sympatico.ca

If you should have any questions concerning your participation in this project now or during the study, you are also encouraged to contact my thesis supervisor, Dr. Louise Jensen, Professor, Faculty of Nursing, University of Alberta at (1- 780 – 492- 6795; louise.jensen@ualberta.ca)

APPENDIX B
INFORMATION SHEET

"In Search of the Meaning of Being an Acute Care Nurse Practitioner"

Principle Investigator:
Judy Rashotte, RN, MScN, PhD Candidate
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Phone : (780) 492-6795
E-mail : louise.jensen@ualberta.ca

INTRODUCTION AND PURPOSE OF THE STUDY
You have been invited to participate in a study that explores the nature of being a nurse practitioner working in an acute care setting. Few studies have been conducted that examine what it means to be a nurse practitioner from their own experiences. Your participation will provide both a descriptive and interpretive account that will contribute to more sensitive, ongoing conversation among those involved with the nurse practitioner movement that includes a deeper, richer articulation of the essence of nursing as embodied in this unique role.

DATA COLLECTION PROCEDURE
You will be asked to participate in one or more face-to-face interviews with me. The first interview is expected to last 1-2 hours depending on your comfort and energy level. If you agree to continue to be involved, a second interview of similar length may be held to continue the exploration of your experience of being a nurse practitioner working in an acute care setting. A third follow-up interview may be scheduled to ensure that I understand the information you have shared with me or I may ask you to read and discuss a draft of the chapters of my dissertation that describe the meanings found. This follow-up discussion may be conducted by telephone and should take approximately one hour or less. The interviews will be arranged at a time and place that is convenient for you. All interviews will be audio-recorded.

POTENTIAL BENEFITS
Although there is no compensation for your participation in this study, you will have the opportunity to reflect on your experiences in as much depth as you choose. Some individuals find that talking about their experience helps them to gain perspective on what has happened in the past, which potentially enables new insights and options to emerge. Should you decide to participate, you will also be contributing to the development of knowledge that may help nursing, other health care professionals and the public at large gain greater understanding into what it means to be a nurse practitioner and a nurse.

POTENTIAL RISKS
In addition to your time commitment, the only risk to you may be a feeling of personal vulnerability associated with the information you choose to share. However, no adverse emotional effects are anticipated.

CONFIDENTIALITY

Confidentiality will be respected at all times. A code number will be used to identify you on the transcripts. Your name and any other identifying information from the tapes will be erased. It is intended that the information and findings of this study will be published and presented at conferences, but again, any identifying information will not be used. Should you not want specific passages from your interviews quoted, you would only need to inform me at the end of the interview. The interview tapes will be kept in a locked file and will be destroyed after the study is completed. If you are agreeable, a copy of the original transcripts will be kept for possible future analysis that may result from ongoing studies related to the nature of being a NP. Only I will have access to all research material. Although I will not obtain further consent from you, appropriate approval will be sought from all appropriate research science and ethical review committees prior to beginning any new study involving your interview data.

PARTICIPATION

Participation in this study is entirely voluntary. You will be free to withdraw from the study at any time and it will not affect your employment. You will simply need to inform me of your decision. You will not have to answer any questions or discuss any subject in the interview if you do not want to. You will be free to stop the interview at any time if you wish. Should you decide at any time during the study that you want to delete any information you shared with me, that information will be immediately withdrawn and destroyed. Your choices will be respected without question. Your continued participation should be as informed as your initial consent, so you will also be encouraged to bring up any concerns or questions you may have during the interviews or course of the study so that we can discuss them.

CONTACT PERSON

If you should have any study-related questions or concerns about this study or your participation, you are encouraged to contact Judy Rashotte at (780) 492- 6795 or my thesis supervisor, Dr. Louise Jensen, Professor, Faculty of Nursing, University of Alberta at (780) 492- 6795.

You may also contact the Patient Relations Department of the Capital Health Authority at (780) 407-1040 with questions or concerns about any aspect of this study.

Participant's Initials: ________________ Researcher's Initials: ________________

APPENDIX C
CONSENT FORM

Title of Project: In Search of the Meaning of Being an Acute Care Nurse Practitioner

Principal Investigator: Judy Rashotte, RN, MScN, PhD Candidate Phone: (780) 492- 6795	Thesis Supervisor: Louise Jensen, RN, PhD Phone: (780) 492- 6795

Part 2 (to be completed by the research subject)

	Yes	No
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached Information Sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time without having to give a reason and without it affecting your employment?		
Has the issue of confidentiality been explained to you?		
Do you understand that the interview data you provide for this study may be re-analyzed in future studies by this researcher without further consent from you, under the condition that approval will be sought from all appropriate science and ethical review committees prior to beginning any study involving the data?		

This study was explained to me by:

____

I agree to take part in this study: YES NO

Signature of Research Participant ____

(Printed Name) ____

Date: ____________________

I believe that the person signing this form understands what is involved in this study and voluntarily agrees to participate.

Signature of Investigator______________________________Date:________________

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT